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OPINION ARTICLE

Importance of Dermatologic Surgery: A Clinical Perspective

Importancia de la práctica quirúrgica en Dermatología: una visión asistencial

M. Just-Sarobé

Unitat de Dermatologia, Hospital de Figueres, Girona, Spain

What is dermatologic surgery? Although there is no single universal definition, we could describe it as that part of dermatology, and in particular, dermatologic therapeutics, devoted to the treatment of disease and disorders of the skin, soft tissues, mucosal tissues, and skin appendages that medical treatment cannot resolve, thus requiring the use of surgical techniques. I find this definition especially sound because it highlights the fact that surgical treatment is indicated only after medical treatment has been ruled out or failed; implicit in applying this principle is the need for correct dermatologic training. We shall see that this is not always the case.

The aim of this article is to express the view I have formed on the surgical aspects of our specialty after almost 14 years as a dermatologist in a regional hospital run by a private foundation, but whose main client is the Catalan Institute of Health (ICS). Certainly, this article does not attempt to be more than the personal opinion of a dermatologist working in an internal medicine department. Thus, it may be the case that some of the opinions expressed cannot apply to the context of large hospitals and that some of the issues pertaining to dedicated dermatology departments are not addressed. For the same reason, some of the ideas presented may sound clichéd or like “leftovers from the past.” However, as I mentioned at the beginning, they are part of my actual practice setting and I assume that many of my colleagues share my opinion.

E-mail address: mjust@wanadoo.es

I discuss the issues by attempting to answer 2 questions. First, how do dermatologists perceive the opinion of other professional groups regarding dermatologic surgery? Second, what does dermatologic surgery mean to dermatologists?

To answer the first question, I am going to examine the perceptions I have seen among different medical and nonmedical groups.

The View of Hospital Managers

There are still many hospitals, including ours, where dermatology is a branch of the internal medicine department. This means that the specialty in general and particularly dermatologic surgery are rarely taken into consideration and fully supported. On many occasions our specialty is “forgotten” when analyzing and taking decisions about surgical issues, with the negative consequences that this entails.

The View of Family and Community Medicine Physicians

Curettage, electrocoagulation, cryotherapy or spindle- or elliptical-shaped excision are relatively easy techniques to learn. The typically long waiting lists of dermatology outpatient units, together with health policies that put pressure on and encourage primary care physicians to perform outpatient surgery, have led to the creation in Spain of the concept of a family doctor specializing in minor dermatologic surgery.

This is the person to whom colleagues refer patients with lesions suitable for excision when they do not consider assessment by a dermatologist to be necessary. On this point, and leaving aside the fact that not all dermatologists believe this to be the solution to the long waiting lists for dermatologic surgery, problems arise when the technique used is inappropriate (for example, surgical excision of seborrhic keratosis or malignant tumors taken to be benign, so that insufficient margins or tumoral tissue is left), when the pathologic diagnosis is unknown to the doctor performing the intervention, or when trivial benign skin lesions are excised. According to Royal Decree 63/1995 on the prioritization of health care services, Annex III, and consistent with a health service with limited resources, the latter procedures are not eligible for funding by Social Security and therefore we do not perform them in our hospital center.¹

The View of Surgeons

If we compare ourselves to general surgeons who do simple skin surgery, we are all aware of the different points of view: for us, the skin is the foundation and target of our surgical training, both in terms of removing lesions and searching for the best outcome. For the majority of general surgeons, skin surgery is a marginal part of their practice, often only appreciated for its impact on productivity levels. Their interest in dermatologic surgical training and final outcomes will logically diverge from ours. However, such “qualitative interest” among dermatologists tends to be associated with fewer interventions per surgical team than is usual for general surgical teams. Much to our regret, it is this level of activity that health managers finally take into account when assigning operating rooms.

The View of the National Health System

Dermatology has preserved its individual character throughout its long history. The content of the specialty, as its name indicates, is both medical and surgical. In order to defend the relevance of dermatologic surgery it is essential that residents be correctly trained. We know that the revised dermatology residency training curriculum currently in effect, as initially drafted and presented by the Ministry of Health, conceived the medical-surgical specialty of dermatology and venereology to fall under internal medicine. This proposal particularly marginalized dermatologic surgery, since it reduced the surgical training of new specialists to the minimum. However, thanks to the work conducted by the Spanish National Commission for Dermatology (Comisión Nacional de la Especialidad) and the Spanish Academy of Dermatology and Venereology (AEDV), and according to the guidelines published by the Spanish National Board of Specialties in Health Science (Consejo Nacional de Especialidades en Ciencias de la Salud), at the moment the specialty of dermatology remains excluded from the core internal medicine training project.

The View of Health Insurance Companies and Cooperatives

Catalonia has a long tradition of cooperative insurance companies and it is quite common for many people to take out private health insurance, in addition to having access to the public health system. If we analyze the schedules of benefits for dermatology applied by these insurance companies, we can, unfortunately, discern a common feature: the ridiculously low fee assigned for the medical procedures we perform. But this is far from the whole story. If we focus on dermatologic surgery specifically, we encounter different scenarios, each one more depressing than the last. Some insurance companies only cover outpatient surgery, while others position dermatology interventions that require an outpatient operating theatre within the categories of general or plastic surgery. Some do in fact have a specific category for dermatologic surgery, but the assigned fee structure is lower than that for general or plastic surgery even though the same intervention code is applied.

The View of Patients

If the surgical side of our specialty is barely understood by nondermatologist physicians, the same is true for some patients. It is quite common for a patient, when seeing the flap used to cover the excision of a malignant tumor, to be surprised by the “huge surgical intervention” performed for the excision of a mere “wart” that was not bothering the patient at all. In other instances we may be the ones guilty of not conveying the seriousness of diagnosing a malignant tumor that requires excision to avoid distressing the patient. Similarly, I am sure many readers have sometimes heard a young patient needing surgery for a facial tumor asking, “But aren't you going to send me to a plastic surgeon?”

The View of Dermatologists

Having reviewed the opinions of other groups, the time has come to ask ourselves what the current status of dermatologic surgery is and what the future holds.

Although for many of us surgery has always been an integral part of our specialty, as much as inflammatory dermatoses, the acceptance of dermatologic surgery by the educational and health administration is relatively recent. In Spain, it was not until 1962 that the Ministry of Education and Science recognized dermatology as a medical and surgical specialty; this led to the name of the discipline being changed to “Medical-Surgical Dermatology and Venereology” in the medical degree. However, the Spanish Ministry of Health continued treating our field simply as a medical specialty until 1978, when dermatology was awarded the full title of “medical-surgical” with all its health, social and professional aspects. Since then, the work conducted by senior colleagues who are aware of the relevance of surgery has been intense and often difficult, and we have to thank them for the fact that our specialty is

recognized as both medical and surgical not only in theory and in training programs, but also in day-to-day clinical routines.

Many dermatologists take an interest in surgery, as reflected both in their practice, their research, and their training efforts. Attesting to this are the work of the Spanish Group of Dermatologic, Laser, and Skin Oncology Surgery, which holds annual meetings; the ongoing publication of quality articles on surgical topics, such as the paper by Samaniego et al² in this issue as well as dermatologic surgery books written by dermatologists; the increasing number of theoretical and practical courses in dermatologic surgery offered by recognized experts in our field; the existence of forums for dermatologic surgery (www.aedv.es); journals such as the *Journal of Dermatologic Surgery and Oncology* (first published in 1975); the International Society for Dermatologic Surgery, founded in 1978, which holds an annual meeting; presentations and posters on the subject as well as a section on new developments in surgery at the AEDV's national conference; and the creation of an on-line atlas of dermatologic surgery (www.cirugiaderma.com).

A very important advantage of having dermatologists deal with benign, premalignant, or malignant skin lesions is that they can remove diseased tissue with greater precision using the most appropriate technique, while preserving healthy tissue, given that they can make a more accurate clinical diagnosis and in some cases they will understand and be able to interpret the histologic features of the target lesion. Something as obvious and basic to medicine as having a diagnosis prior to treatment is sometimes ignored when nondermatologist physicians make forays into skin surgery. I am sure that this notion of "lumpoma" surgery is familiar to all of us, and it sometimes leads to the need for a second biopsy procedure or the reexcision of a tumor—both of which procedures are avoidable with good praxis—with the consequent discomfort for the patient and unnecessary health costs for the National Health System. In this regard, what dermatologist has never received an urgent referral or a call from a nondermatologist colleague asking for help on how to proceed after receiving the pathology report for a lesion that has been excised without having first made a clinical diagnosis?

Similarly, when a single specialist or team of specialists makes a provisional diagnosis, performs the surgical procedure and the post-excision follow-up and clinicopathological correlation if needed, then the entire process is both continuous and consistent. This clearly has an impact on the quality of care and consequently on the well-being of the patient.

The majority of dermatologic surgical interventions are performed on an outpatient basis without hospitalization and under anesthesia administered by the surgeon. In general, these procedures are very well tolerated by the patient. A large number of such interventions are performed in a conventional examining room as part of a scheduled consultation. This apparently high capacity to resolve problems is not always perceived as an indicator of quality care if we compare ourselves with other specialties that treat skin tumors: removing a nodular

basal cell carcinoma in clinics on the same day as the consultation, using curettage and electrocoagulation, just does not translate into the same sense of complexity as removing a malignant tumor in the operating theatre, even though the former is more comfortable for the patient, cheaper for the National Health System, and equally effective if the procedure is clearly indicated and performed correctly.

I have referred in the last 3 paragraphs to 2 aspects to take into account when attempting to convince health managers of the need for dermatologic surgery: quality of care and savings in health spending.

So, what does the future hold? If we analyze the demand for care we might think that the future looks very promising. In this regard, different studies and numerous skin tumor registries, including those for melanoma and nonmelanoma skin cancer, show that benign and malignant tumors together account for a large part of our clinical practice, possibly over 40% of dermatologic visits³ or even 50% if we focus on patients older than 65 years.⁴ In contrast, up to 17% of visits are related to premalignant and malignant lesions, which absolutely require treatment⁵ and this percentage seems to be increasing because of sunbathing and population aging.⁶ The future of dermatologic surgery, and skin cancer surgery in particular, should therefore be more than assured. However, as I have mentioned, the long waiting lists for dermatology visits—some of which are due to the lack of dermatologists, while others are due to the lack of dermatologists who want to work in the conditions offered by National Health System—have led to the appearance of "minor outpatient surgery" by family doctors using basic dermatologic surgical techniques, with the result that many skin tumors are not treated by dermatologists.

Regarding Mohs micrographic surgery, although health managers are not interested in the use of a "slow" technique, we have to convince them, demonstrating that it is the safest technique to remove certain types of skin tumor, in relation to location or recurrence, as in such cases the Mohs technique is cost-effective over the long term because it avoids new interventions.⁷

In turn, esthetic-cosmetic dermatologic surgery, an area half-way between our specialty and plastic surgery, is on the increase because it is linked to social and economic prosperity. However, there is an ever-increasing number of physicians performing this type of surgery who are neither dermatologists nor plastic surgeons and who, in addition, are pressing to establish this area as an independent specialty. Obviously, this field has limited room to maneuver within the National Health System, but it does have great potential in the private sector, although it is also the area most vulnerable to crises such as the current one. To defend our role in this setting, proper residency training is of great importance. Many of us have ended our training with very limited knowledge of these techniques, and this type of surgery would be very difficult to claim as our own if not included in our training program.

Despite the concerns expressed here, one thing is very clear: the future of dermatology in general, and dermatologic surgery in particular, is not going to be decided by the patients, dermatologists, or dermatology

associations, but rather by the government. As Prof F Camacho⁸ stated, the mission of dermatology departments or services will be to “teach” all areas of dermatologic surgery, create “diagnosis, treatment and follow-up departments,” monitor all aspects of dermatologic surgery and develop the full potential of oncologic and cosmetic dermatologic surgery such that, when the moment is right, it can be presented as “an instance of social progress.” On the other hand, it should be the role of national and international associations such as the AEDV and the European Academy of Dermatology and Venereology to not only “teach” but also “convince” the health authorities of the need for dermatologic surgery.

Finally, the noninclusion of our specialty as a part of internal medicine training has been a great step forward in maintaining the status of dermatologic surgery. It still remains to be seen what the training curriculum will finally consist of; after all, this is where the seeds of the future are planted.

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