

Are Additional Tests Indicated in Ambulatory Dermatologic Surgery?☆



Realización de pruebas complementarias en cirugía dermatológica ambulatoria ¿existe indicación?

Many questions continue to surround the perioperative management of patients undergoing ambulatory dermatologic surgery. The lack of studies specifically in the area of dermatologic surgery makes it difficult to manage situations linked to the surgical procedure, such as anti-aggregation/anticoagulation, antibiotic prophylaxis, and additional preoperative tests. In the absence of specific guidelines based on sufficient scientific evidence, dermatologists extrapolate data and conclusions from similar procedures in other specialties. This is why studies such as the one by Nieto-Benito et al are essential in our specialty.¹ In their study, the authors evaluate the impact of implementing a preoperative protocol that limits the performance

of additional tests to patients with specific comorbidities. The data show a considerable reduction in health care costs with no corresponding increase in the number of surgical complications, in comparison to previous periods in which the protocol was not applied. These conclusions lead the authors to suggest that routine ordering of additional tests in dermatologic surgery is inappropriate.

Performing studies on the preoperative pertinence of additional tests is essential in dermatology. This would allow us to base the decisions we make in routine surgical practice on better scientific evidence.

Reference

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A Mnemonic for Reconstructing Acquired Scalp Defects☆



Una regla nemotécnica para la reconstrucción de defectos quirúrgicos en el cuero cabelludo

The excision of tumors from the scalp is a frequent procedure in dermatologic surgery. The specifics of anatomy in this region, which is equipped with a musculoaponeurotic system that offers little elasticity, prevent repairing a defect by direct closure when it is greater than 2 cm in diameter. The scalp is also highly vascularized and the abundance of anastomoses available favors the survival of flaps even if their pedicles are narrower than is usual. Medium-sized scalp defects are therefore often reconstructed with flaps, the most commonly used ones being the classic rotation flap or the O-Z double rotation flap. These reconstructions achieve their objective, but at the expense of detaching and mobilizing fairly large areas of tissue.

In this issue of *Actas Dermo-Sifiliográficas*, Francisco Russo¹ analyzes his experience repairing scalp defects in a series of over 100 patients using a mnemonic “1–2–3” rule for starting the reconstruction of medium-sized defects of 1 to 4 cm. The rule refers to starting the process with 1, 2 or 3 release incisions depending on whether the defect measures 1 to 2 cm, 2 to 3 cm, or 3 to 4 cm. About half the cases in the series were repaired using these release incisions. When closure cannot be achieved with this initial approach, the author proposes extending the incisions to create classic flaps.

The author has previously given other original suggestions to help us make improvements in our customary surgical procedures.² This issue’s article offers a practical, simple, and stepped approach to reconstructing defects after scalp surgery.¹

Reference

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2. Russo F. Mercedes Flap With Releasing Incisions for Scalp Defects. *Ann Plast Surg.* 2017;79:149–55.

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Sentinel Lymph Node Biopsy[☆]



Biopsia selectiva del ganglio centinela

Sentinel lymph node (SLN) biopsy is currently considered the gold standard for nodal staging in cutaneous melanoma.

The technique, however, has been surrounded by controversy since it was first described by Morton et al.¹ in 1992. In the initial years, when it was theorized that melanoma spread according to a stepwise pattern, SLN biopsy was used to reduce the performance of unnecessary lymph node dissections.

SLN biopsy provides information on lymphatic drainage basins, enabling more accurate patient follow-up. It can also be used to identify subclinical disease in patients who could benefit from early adjuvant treatments that are showing very promising results.

The discovery, however, that SLN biopsy does not improve overall survival and can only offer prognostic information, combined with the emergence of new models explaining melanoma spread (e.g., the simultaneous and differential spread models),² called for increasing caution regarding its use.

This article presents a retrospective review of complications and sequelae in 124 patients with primary melanoma who underwent SLN biopsy. The authors found a

high rate of complications (37.9%) compared with previous studies, but this could be because they also considered complications in patients who underwent subsequent lymph node dissection. The authors argue that clinicians must not only carefully analyze the already controversial use of SLN biopsy, but also weigh up potential benefits and risks.

Risk of surgical complications must always be assessed on a case-by-case basis before indicating SLN biopsy.

Reference

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2. Pizarro Á. Linfadenectomía tras una biopsia positiva del ganglio centinela en el melanoma: un cambio de paradigma. *Actas Dermosifiliogr.* 2018;109:293–384.

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