Larger Margins Urged For Melanoma Excision

**BY ALICIA AULT**

**AUSTIN, Tex. —** The commonly accepted standard of using 5-mm margins for surgical excision of melanoma in situ may not be enough to clear the large majority of tumors, said Dr. Joë Kunishige.

Speaking at the annual meeting of the American College of Mohs Surgery, Dr. Kunishige, a dermatologist in private practice in Pittsburgh, said that since several studies have shown a 5-mm margin to be inadequate, she and her colleagues gathered the latest evidence on clearance rates to update previous National Institutes of Health guidelines, set in 1992 (NIH Consens. Statement 1992;10:1-26).

The goal was to clear at least 97% of tumors.

They evaluated all primary melanoma in situ cases that were collected as part of a prospective database that started in 1982 at the practice. The database included 1,072 patients with 1,120 primary tumors. Of the patients, 675 (63%) were male, mean age was 65 years, and mean follow-up was 4.7 years. A total of 593 (53%) of the lesions were on the extremities, and 201 (18%) were on the face, 235 (21%) were on the trunk, with the remainder in other locations.

All lesions were excised using the fresh margin technique of Mohs surgery, with frozen section examination of the margin.

Using 6-mm margins, 86% of the tumors were cleared. With a 9-mm margin, there was a 98% clearance rate; and with a 12-mm margin, a 99.4% clearance rate, said Dr. Kunishige.

The 9-mm margin was equally effective regardless of sex, location, or diameter of the lesion, she said. The overall 5-year survival was 93%; the 5-year melanoma in situ survival was 99.5%. Three patients died of melanoma in situ. Two died from a separate invasive melanoma, and 90 died of other causes, free of melanoma. The overall survival curve was what would have been expected for this age group, she said.

The overall recurrence rate in this evaluation was 0.3%. Three patients had a local recurrence, with reappearance of tumors at 9, 10, or 11 years. Dr. Kunishige and her colleagues concluded that a 9-mm margin was superior to the 6-mm margin, with a P value of less than .0001. She reported no disclosures.

Psoriasis Studies Conflict On CV Mortality Risk

**BY KATE JOHNSON**

**MONTREAL —** Mortality rates are significantly increased in patients with severe psoriasis compared with the general population, according to two new studies.

But the studies have conflicting results regarding cause of death, researchers reported at the annual meeting of the Society for Investigative Dermatology. A study by Dr. Rahat Azfar showed an age-dependent, significantly increased risk of cardiovascular death with severe psoriasis, compared with patients without it.

“Severe psoriasis may be an independent risk factor for cardiovascular mortality,” noted Dr. Azfar of the University of Pennsylvania, Philadelphia, whose study showed a 50% increase in cardiovascular death.

Her findings are in direct contrast to another study presented in the same session and conflict with a growing body of evidence. Dr. Robert Stern presented results from the 30-year PUVA Follow-Up Study, which showed no increase in cardiovascular death risk in severe psoriasis patients, all of whom had undergone PUVA.

“In patients with extremely severe psoriasis, there is an increased risk of death from noncardiovascular, but not cardiovascular causes,” said Dr. Stern, professor of dermatology at Harvard Medical School and vice chair of dermatology at Beth Israel Deaconess Medical Center in Boston.

“Previous studies of cardiovascular mortality have not controlled for traditional CV risk factors, as our work has done,” commented Dr. Azfar, who declared no conflicts of interest.

“In patients with extremely severe psoriasis, there is an increased risk of death from noncardiovascular, but not cardiovascular causes,” said Dr. Azfar.

The data show “that liver disease and nonmelanoma skin cancer accounted for more than half the approximately 70 excess deaths we observed,” he said.

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Dr. Azfar, who declared no conflicts of interest, agreed that cardiovascular risk factors are important, but his data suggest they are no more important than other risk factors.

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Dr. Azfar of the University of Pennsylvania, Philadelphia, whose study showed a 50% increase in cardiovascular death.

His prospective study followed 1,376 patients from the PUVA Follow-Up for 28 years, from 1976 to 2004.

Comparing the observed and expected mortality rates among patients and controls, the researchers found an increased all-cause mortality rate among only those patients with the most severe psoriasis. When cause of death was examined in this group, noncardiovascular reasons explained the increased risk, and there was a non-significant increase in the rate of cardiovascular deaths, compared with controls, Dr. Stern said.

Beer Consumption Associated With Increased Psoriasis Risk

**BY KATE JOHNSON**

**MONTREAL —** Women who drank alcohol, especially those who consumed at least five beers per week, were at increased risk of developing psoriasis, based on an analysis of the Nurses’ Health Study.

Compared with abstainers, women who drank alcohol (defined as consumption of at least 30 g or roughly two drinks, per week) had a significantly increased risk of developing psoriasis, with a relative risk (RR) of 1.59, said Dr. Patrick Dominguez, who presented his findings at the annual meeting of the Society for Investigative Dermatology.

When type of alcohol was examined, however, only regular beer consumption of more than five drinks per week was a significant predictor (RR 1.83) for the development of psoriasis. “For any amount of light beer, wine, or liquor consumed, the relative risks were not significant.”

At study entry in 1989, women in the Nurses’ Health Study were asked about their level of alcohol consumption in grams per week. According to the Centers for Disease Control and Prevention, a standard drink contains 13.7 g of alcohol and is defined as 12 ounces of regular beer, 8 ounces of malt liquor, 5 ounces of wine, or 1.5 ounces of 80-proof distilled spirits.

Over a 14-year period, biennial questionnaires were used to monitor both the amount as well as the type of alcohol consumed (regular beer, light beer, wine, or liquor), said Dr. Dominguez, who is a research fellow in the department of dermatology at Brigham and Women’s Hospital in Boston.

In 2005, participants were asked if they had psoriasis. A total of 2,169 reported a diagnosis of psoriasis; 1,162 were prevalent cases and the remaining 1,007 were incident cases, said Dr. Dominguez, who declared no conflicts of interest.

After excluding incident cases for which there was incomplete information on alcohol consumption, 935 participants with new onset psoriasis were available for analysis.

The abstainers and women who drank alcohol did not differ significantly in age. Abstainers had slightly higher body mass indices. Drinkers were more physically active, and a higher percentage of drinkers also reported current or past smoking.

“We also measured dietary folate, which may be a modifiable for alcohol’s effect in psoriasis, and folate intake was higher in the drinkers, but not significantly higher,” Dr. Dominguez said.

One possible explanation for the study’s findings is that gluten, a nonalcoholic ingredient found in beer, might trigger the onset of psoriasis, he speculated.

“There are multiple case series in which patients with gluten sensitivity, or celiac disease, and psoriasis go on a gluten-free diet, and their psoriasis clears up,” he said in an interview. “Beer is the only alcoholic drink that contains gluten. Light beer has some gluten but much less.”
Surgical margins for standard excision should include 9 mm of normal-appearing skin for melanoma in situ, according to a recent study. Historically, melanoma in situ has been treated with excision of the brown patch and about a 5 mm extra of normal-appearing skin. “That is the current standard. Those simple excisions with 5 mm margins have about an 80 percent recurrence rate, which is related to 5 mm margins not clearing the entire tumor 10 to 50 percent of the time. The current standard is not adequate,” she says. In addition, today, dermatologists are increasingly treating melanoma in situ and inadequate treatment frequently leads to recurrence as invasive melanoma. Recent research. After initial excision biopsy, the radial excision margins, measured clinically from the edge of the melanoma, should be 5-10 mm (measured with good lighting and magnification) with the aim of achieving complete histological clearance. Melanoma “in situ” of non-lentigo maligna type is likely to be completely excised with 5mm margins whereas lentigo maligna may require wider excision. Minimum clearances from all margins should be stated/assessed. Consideration should be given to further excision if necessary; positive histological margins are unacceptable. Complete surgical excision of melanoma in situ (MIS) is curative. A 5-mm margin is often taken as the standard primary excision margin despite increasing evidence that this is frequently inadequate for tumor clearance. OBJECTIVE. To calculate the proportion of patients requiring >5 mm margin for clearance and to investigate any patient/lesion characteristics necessitating larger margins. Materials and methods. Three hundred forty-three primary MIS cases on the head and neck treated in the authors’ department by Mohs micrographic surgery (MMS) over a 65-month period were retrospectively analyzed. Records were made of patient and lesion characteristics, and the total surgical margin for clearance calculated. RESULTS.