The Mohs and Me

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"If you have to have cancer," the nurse said, "this is the one to get." I had just been diagnosed with basal cell carcinoma (BCC), a form of skin cancer occurring more than any other cancer — over a million new cases in the USA annually.

The nurse is right; compared with others, this is an "easy" cancer. It's normally slow growing, and its cure rate using Mohs is 99%.

Basal cell carcinoma
Used with permission of the American Academy of Dermatology

Cancer had not occurred to me. One day as I was seeing my internal medicine physician on another matter, his eagle eye spotted what I considered a small, sort of doughnut-shaped red blemish about three-fourths an inch under my right eye. "Looks like cancer," he said and had someone make an appointment for me to see a dermatology surgeon.

GETTING STARTED

The surgeon was ready to do my biopsy when I got there. I asked what local anesthetic he would be using and explained it was important to reduce the dose for me to avoid the polio-related weakness and serious side effects I encountered in the past. He measured the lesion – 6 mm, about the diameter of a pencil eraser. As I sat in my power chair, he deadened the area with 1 cc of lidocaine, took the required slice for the biopsy, and the entire procedure was over in minutes. The nurse scheduled me for surgery in ten days, in case the biopsy proved I had cancer.

I had left some excellent anesthesiology material from PHI with the surgeon. When his nurse called to confirm my BCC, I told her I was concerned about using lidocaine, knowing it affects nerves. I explained that the right side of my throat is paralyzed and I cannot swallow solids (among other swallowing difficulties). I added that my neck and upper body are considerably paralyzed, and my breathing is compromised by weak muscles. I wanted to be sure we got this anesthesia thing right. She replied that the doctor had read the articles and deemed the information "irrelevant." I said a silent "goodbye" to this doctor.

GETTING HELP

Immediately I wrote Selma Calmes, MD, retired anesthesiology expert, explained my situation, and asked for advice.

I called the office of the dermatologist who had removed my husband's skin cancers, David Watts, MD, described my physical limitations to his nurse, and asked for an appointment to talk with him. She said she'd get back to me.

Four things happened that told me I had hit pay dirt:

- Dr. Watts called me back, himself.
- He had already searched for and read available articles pertaining to the anesthesia problem his nurse relayed to him.
- When I told him I had written Dr. Calmes for advice, he asked me to have her send a copy of the answer to him, as well.*
- Before he hung up he said, "I'm really glad you called me, Nancy."

Dr. Watts's response almost made me weep. It made one very important truth clear to me: It is possible to find doctors who possess "that special quality." A day later I called for an appointment to see Dr. Watts. The nurse asked me to have the biopsy slides sent to their office and said she'd get back to me.

Again, Dr. Watts returned my call. I told him it frightened me to think of losing more of my ability to swallow

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*Carter's question and Dr. Calmes's advice is at www.post-polio.org/net/help12.html

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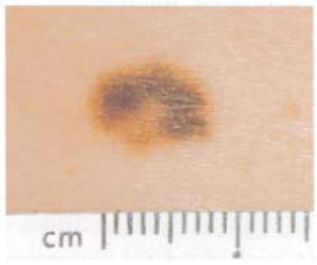
Asymmetry

Border irregularity

Color



Diameter

Melanoma
Most moles are harmless, but watch for a change in appearance using the ABCD rule.

or speak or breathe by not making judicious decisions regarding the local anesthetic to be used. I had experienced problems before from anesthetics administered in "nothing" procedures, and I wanted to be sure what he used didn't present more of a risk than the cancer did. I mentioned I'd been having spasms in my throat since the biopsy.

MOHS

Dr. Watts is a board-certified dermatologist who is fellowship-trained in Mohs surgery through an accredited program at the American College of Mohs Surgery. He completed two years of Mohs training in addition to his three-year dermatology residency. Dr. Watts performs over 50 Mohs surgeries a month.

Mohs micrographic surgery is a technique devised in the 1930s by a University of Wisconsin medical student named Frederic Mohs and refined by others over the years. Here's what happens: A surgeon injects a local anesthetic, removes the tumor and a thin layer of surrounding tissue, constructs a schematic map, and carefully checks the tissue while the patient waits for results. In a process that can take over an hour, the tissue is frozen and then examined under a microscope. If cancer cells remain in the undersurface or edges, the surgeon takes another thin layer, pinpointing those malignant sites for examination, and repeats this process until no cancerous tissue remains.

In two-thirds of the cases, surgery on small-to-medium-sized cancers can be completed in only one pass. But since there is no way to predict exactly how extensive the cancer is, it could be necessary to repeat the procedure numerous times, thus requiring multiple injections of anesthetic. Mohs is usually done in the surgeon's office, where he has the required surgical and laboratory facilities.

GETTING INFORMATION

By the time we met, Dr. Watts and I had both read Dr. Calmes's thoughtful reply to my plea for help. She offered a number of observations and suggestions that Dr. Watts helped me understand:

- Since we have no data regarding the effects of local anesthetics in polio-damaged peripheral nerves, the surgeon needs to consider the concentration of local anesthetic used to deaden the area (with lidocaine being the best option at this time) and what to do about adding epinephrine, used to decrease bleeding during surgery and to prolong the numbness.
- Because it is remotely possible for some of the local anesthetic injected at the site to travel down through the infraorbital foramen (a tiny canal in the front surface of the upper jaw bone), this could block some motor fibers to the tongue and throat area. Such an event might be avoided by injecting a smaller-than-usual amount of the local anesthetic and keeping the patient in a head-up position.
- Using the least possible amount of anesthetic and epinephrine while proceeding as quickly as possible would be best. Having the patient remain in a position as upright as practical would mean less bleeding and would assure better function from polio-damaged breathing muscles. Dr. Calmes then emphasized the necessity for doing all of this in a way that fulfills the surgeon's need to work within his comfort zone, as well.

For more information:

American College of Mohs Surgery
— www.mohscollege.org

American Academy of Dermatology
For explanations, demonstration video and list of surgeons worldwide — www.aad.org

GETTING READY

Dr. Watts began by discussing my specific polio needs with me, one by one. Up to this point, everything had been done with me sitting in my power chair. I didn't realize this surgery is usually performed with the patient lying on an operating table. I had not been supine in twenty years. When I mentioned this to Dr. Watts, he said this was "no time to start," and determined he'd do the surgery with me in an examination chair.

"Crutch" for chin

We rehearsed. As Dr. Watts slowly reclined the chairback to about 15 or 20 degrees off of vertical, we kept my air passage open by elevating my chin with my "chin crutch." We supported my shoulders (which have a tendency to dislocate) with pillows and a sash wrapped behind them so I could pull them forward if they started slipping out of socket.

The doctor marked my face as if for surgery and explained exactly what he intended to do. First, he would partially anesthetize the skin by icing the area to make injecting the anesthetic a more pleasant experience. Instead of the normal 3 to 4 cc's of lidocaine, he would use about 1 cc. Since he believed the long-lingering numbness of my biopsy was due more to epinephrine than to lidocaine, he used a concentration of only 1 part epinephrine to 200,000 parts lidocaine, rather than the usual 1 part to 100,000. So that he would have to numb the area only once, he planned to take more aggressive margins (2 to 3 mm rather than the usual 1 to 2) as he removed the tissue surrounding the cancer. He would then suture the wound closed immediately after the first pass, betting that the microscopic examination would confirm the cancer was gone and no more surgery was needed, thus escaping the necessity for additional lidocaine. I felt secure. I knew I was in the right hands.

At the same time, I continued to prepare myself for the coming experience. Each day I drank a high-protein Ensure to boost my energy level. And I continued my daily meditations, focusing on bringing healing energy and relaxation into my mind and body.

S-DAY AND BEYOND

On the day of the surgery, I felt serene and fully prepared. Dr. Watts strode into the room humming and ready to go. We followed our plan. All of the cancer was removed in the first pass. Everything came off perfectly. I don't mean to suggest that my full body was not affected by this surgical invasion; it was, as it always is. I felt weaker and more vulnerable for a time. But I did avoid the throat spasms I underwent after the biopsy and had none of the extreme repercussions I had feared.

What made it so easy is that Dr. Watts is an extraordinary man. What motivates a doctor like this? He says what he does is fun, that he gets to help people of all ages. His work encompasses everything in medicine, from surgery to psychology, a neat little package all tied up somehow with the way he relates to people. He enjoys the magic his coordination and skills produce.

Whatever it is, I got lucky. ▲

As for Dr. Watts, he leaves us with a message: As skin cancer becomes more common, individuals need to focus on these considerations:

Prevention: Avoid direct sun on the skin, particularly middle-of-the-day sun, which is more carcinogenic. Avoid sunburn. Avoid tanning beds.

Early detection: Have an appreciation for what skin cancers look like. Melanoma, for example, can be easy to cure if caught early – and can be deadly if not.