

Shave Excisions in Melanoma Management: Time to re-think the guidelines?

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INTRODUCTION

- Australia has the highest rate of melanoma in the world.¹
- Public health campaigns have led to a population attuned to the hazards of sun exposure and the desirability of skin checks.²
- The last four decades have seen significant rises in melanoma diagnosis, especially in situ disease.³
- Melanoma guidelines advise against any initial diagnostic procedure other than formal excision, except in special circumstances.⁴
- The supporting evidence is limited and this is a Grade C recommendation: the body of the evidence provides some support for recommendation(s), but care should be taken in its application.
- Guidelines advocate for use of digital imaging to monitor suspect lesions with a claimed benefit of earlier diagnosis and fewer benign excisions.⁴

SHAVE PROCEDURES

- Shave procedures are widely, effectively and safely used by Australian and international dermatologists for initial melanoma diagnosis.⁵
- They are cost effective, time-efficient and produce acceptable cosmetic outcomes.⁶
- Shave excision is only appropriate if the clinician is confident the lesion can be removed in width and depth.⁶
- Base transection is rare when lesion selection and operative technique are optimal (**Fig 1**).
- Appropriately performed shave excisions remove thin, small-diameter melanocytic lesions in their entirety with no greater incidence of margin involvement than an ellipse.^{7,8,9}



Fig 1. a) A pigmented lesion concerning for malignancy from a patient's back that appropriately underwent shave excision **b)** Histopathology slide shows the lesion is well clear in width (vertical purple arrows) and depth (diagonal purple arrows).

MONITORING vs EXCISION

- Short term monitoring aided by total body photography (TBP) and digital dermoscopic imaging (SDDI) is an alternative to excision.
- Importantly, there is currently no study of digital monitoring demonstrating survival benefit.
- Recent work shows that a three-month delay in treatment of Stage I melanoma (including IA and IB) results in increased disease specific mortality.¹⁰
- Studies of digital dermoscopic imaging reveal delays of months or even years before eventual excision of invasive and even thick melanomas.⁶
- Recent studies document far superior in situ to invasive ratios when immediate excision of suspect lesions rather than monitoring is employed.⁹

DO GUIDELINES NEED TO CHANGE?

- Current studies suggest that increased use of shave excision results in more melanomas being diagnosed, with far more favourable in situ to invasive ratios and reduced delayed diagnosis of melanoma.^{7,8,9}
- The majority of melanomas diagnosed are in situ or <1mm thick and readily cleared by a competent shave.¹¹
- Reluctance to use shaves may suggest lack of training and confidence in lesion selection and technique.
- Current guidelines do not reflect the available evidence on the relative merits of formal excision and shave excision.

CONCLUSIONS

- One of the aims of skin examination would be to diagnose as many melanomas as possible whilst in situ, or if already invasive at the first opportunity.
- Ready access to a safe, simple, quick, low morbidity and low-cost diagnostic procedure favors these outcomes.
- Formal ellipse places a far greater financial and time burden on patients and their clinicians.
- Appropriate use of a simple and low morbidity procedure can aid early diagnosis of melanoma.
- Training and confidence in lesion selection and shave technique lead to more frequent utilisation of the procedure, more favourable in situ-to- invasive melanoma ratios, fewer thicker melanomas and insignificant rates of base transection or upstaging.⁶
- Guidelines should reflect the above.

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