

## **Skin Surgical Procedures**

This information leaflet provides a brief overview of procedures which may be suggested as part of your treatment. All are performed after local anaesthetic injection to numb the skin.

### Curettage

A superficial scraping procedure usually reserved for removal of benign lesions.

### Shave or Scoop Biopsy

A more precise superficial procedure used in removal of benign lesions eg. protuberant moles and some low risk skin cancers.

### Punch Biopsy

A punch biopsy is a procedure in which a small core of skin is removed and sent to the laboratory for analysis, to establish a diagnosis. The resultant circular defect is usually closed with two or three stitches which tend to be removed after seven days by a nurse.

### Incision Biopsy

An incision biopsy is when part of a lesion / rash is removed for analysis, using a scalpel (sharp surgical knife). The defect is closed side-to-side with several stitches, which can be removed after seven to fourteen days by a nurse.

### Excision Biopsy

Complete removal of a skin lesion / mole. As for an incision biopsy, the area is usually closed with several stitches (almost always in 2 layers). The deeper sutures are placed under the skin to hold the defect together which helps reduce tension on the top layer of sutures and which usually need removed or may be dissolvable – depending on the body site.

### Wider re-excision or Wide Local Excision

This surgical procedure is sometimes performed on patients who have had previous surgery for skin cancer. A margin of normal looking skin from around and under the operation scar is removed to make sure that no skin cancer cells are left behind. The amount of skin removed depends on how deeply the skin cancer had gone into the skin as reported in the first biopsy; it is often at least 5mm and up to 2cm of further tissue may be taken from around the original surgical site.

### Full Thickness Skin Graft (FTSG)

After local anaesthetic injection, a piece of skin is harvested from one part of the body (donor site) and used to cover the surgical defect (recipient site). Skin is taken from areas where there is spare skin eg. in front of or behind the ear, over the collar bone or the upper inner arm. These areas are used because they are easy to stitch together again after the skin has been taken and they are not so important cosmetically although there will be a second scar. The donor skin is thinned then sutured in place to fill the defect. The pros and cons of this approach versus other options eg. a local skin flap or allowing a defect to heal by itself (spontaneous granulation and re-epithelialisation) will be discussed. Sites where a FTSG is more often used include defects on the scalp, nasal tip, ear and dorsal hand. Sutures are

removed 7-14 days later depending on the site and nature of suture material. The appearance is usually satisfactory but the match to the surrounding skin is rarely perfect so there will be a degree of visible difference which may make the graft stand out from the surrounding skin. The skin graft relies on the wound bed for its blood supply and occasionally (1%) can fail. Avoiding smoking after a skin graft can help reduce the risk of failure. As with all skin operations there is a risk of infection and bleeding from both the recipient and donor sites.

### Split Thickness Skin Graft (STSG)

A very thin layer of skin is taken by a shaving technique, usually from the outer thigh (called the donor site), and placed over the wound where the lesion was removed. The donor site is covered with sterile dressings, which remain in place for several days at a time, then need changed as considerable seepage often occurs. A degree of discomfort is common from the donor site which can take up to 2 months to heal by itself like a large graze. Dissolvable stitches are often used to hold the skin graft in place. Regular dressing clinic appointments are useful until the areas are completely healed. The common site of a STSG is the lower leg.

### Local Skin Flap

This surgical technique may be used to close a surgical defect after removal of a skin cancer. There are many different kinds of design of local skin flaps. All local skin flaps involve moving a piece of local ie. surrounding skin to close the wound. Careful consideration will be given to choosing what is considered the best option to give the optimum functional and aesthetic outcome. This technique is used for more challenging anatomical sites or larger defects when the surrounding skin is too tight to close side-to-side or where there would not be a good enough blood supply for a graft or when spontaneous healing would give an unpredictable and possibly poor outcome. Skin flaps are used most commonly on the face. A number of extra cuts (which may be quite large) are made in the adjacent skin to mobilise it into its new position in the surgical defect and stitch it into place. Every effort is made to camouflage these incisions by placing them in the natural skin lines. The area is protected with a sterile pressure dressing usually for 2-3 days and the stitches remain in place for seven days when a review is arranged. Skin flaps tend to give a good match to the skin of the wound. Flaps may become infected or bleed like any other skin procedure and occasionally may breakdown resulting in prolonged healing time and possible increased scarring. Avoiding smoking after a skin flap can help reduce the risk of failure.

### Spontaneous healing

Sometimes the size and site of a surgical defect on the skin lends itself to natural healing to give the best outcome. This may be the preferred option for the patient and should always be considered. There are advantages and down-sides to such an approach and a discussion of the options is best made on an individual basis. Gradual granulation of the defect occurs with contraction of the edges then a new skin forms (re-epithelialisation) which is scar-like in quality. Full healing usually takes approximately 6 weeks. For the first 3 weeks the site is often best covered with a dressing which is changed 2-3 x weekly. Initially the dressing is very absorbent

(alginate) and latterly the dressing is minimally absorbent but promotes healing (duoderm thin). After a few weeks, the site is usually well on its way to healing and quite dry and can then be left open to the air. Use of a petroleum jelly ointment 3 x daily eg Vaseline is useful from then on to help complete the healing and new skin formation.

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