Table II. Melanoma characteristics with ABCD scores of <2 versus ≥2

Characteristics	ABCD < 2 (n = 28), n (%)	ABCD ≥ 2 (n = 244), n (%)	*P* Value
Initial detection			
Physician detected	11 (8.0)	126 (92.0)	.273
Patient detected	16 (12.0)	117 (88.0)	
Melanoma type			
In situ	11 (7.5)	136 (92.5)	.098
Invasive	17 (13.6)	108 (86.4)	
Breslow thickness, mm			
<0.8	23 (9.8)	211 (90.2)	.564
≥0.8	5 (13.2)	33 (86.8)	
Pigmentation			
Amelanotic melanomas	2 (16.7)	10 (83.3)	.361
Pigmented melanomas	26 (10.1)	231 (89.9)	

greater prevalence of melanomas under 6 mm in diameter.

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REFERENCES

1. Friedman RJ, Rigel DS, Kopf AW. Early detection of malignant melanoma: the role of physician examination and self-examination of the skin. *CA Cancer J Clin*. 1985;35(3):130-151.
2. Thomas L, Tranchand P, Berard F, Secchi T, Colin C, Moulin G. Semiological value of ABCDE criteria in the diagnosis of cutaneous pigmented tumors. *Dermatology*. 1998;197(1):11-17.
3. Fernandez EM, Helm KF. The diameter of melanomas. *Dermatol Surg*. 2004;30(9):1219-1222.
4. Abbasi NR, Yancovitz M, Gutkowicz-Krusin D, et al. Utility of lesion diameter in the clinical diagnosis of cutaneous melanoma. *Arch Dermatol*. 2008;144(4):469-474.
5. Stojkovic-Filipovic J, Kittler H. Dermatoscopy of amelanotic and hypomelanotic melanoma. *J Dtsch Dermatol Ges*. 2014;12(6):467-472.

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Efficacy of staged excision with permanent section margin control for melanoma in situ

To the Editor: Treatment of melanoma in situ (MIS) with staged excision has been shown to result in better margin control and lower recurrence rates than wide local excision. The aim of this study was to review our institution's experience with staged excision of MIS and document the margins required for clearance.

We performed a retrospective review of all patients with MIS treated with staged excision from 2014 through 2019 at our institution. The square procedure, as described by Johnson et al,[1] was performed in all cases. The tissue was processed as a formalin-fixed permanent section and analyzed by a dermatopathologist with en face sectioning of circumferential peripheral margins. The first stage was excised with a 5-mm margin around clinically visible tumor, with subsequent stages excised by adding an additional 5 mm to positive margins. Once all peripheral margins were clear (no histologically visible tumor at en face margin), excision of the remaining central tissue (biopsy site and surrounding intact skin) was submitted for vertical sectioning, followed by immediate reconstruction. Any patient with a melanoma less than 50% sampled by initial biopsy underwent a completion biopsy for staging before treatment. A total of 342 cases were reviewed. Three of these cases were found to have an invasive component after the central debulking procedure and were therefore excluded from analysis. The average patient age was 65 years (range, 20-96 years), and the male-to-female ratio was 1.4:1. The majority of cases performed were on the head and neck and were further subdivided into nose (n = 13), ear (n = 12), periocular (n = 11), scalp (n = 14), and other head and neck (n = 120). Further anatomic sites evaluated included the trunk (n = 53), upper extremities excluding hands/feet (n = 56), lower extremities excluding hands/feet (n = 41), and hands/feet (n = 19).

Table I. Procedure characteristics and recurrence data for melanoma in situ treated with staged excision

	Body site	Cleared on first stage (%)	Average stages to clear	Recurrences (%)
Total	339	275 (81.1)	1.26	3 (0.9)
Head & neck	170	123 (72.0)	1.41	1 (0.6)
Nose	13	11 (84.6)	1.23	0
Ear	12	9 (75)	1.25	0
Periocular	11	5 (45.5)	1.82	0
Scalp	14	11 (78.6)	1.29	0
Other head & neck	120	87 (72.5)	1.43	1 (0.8)
Trunk	53	49 (92.5)	1.08	0
Upper extremities	56	47 (83.9)	1.2	0
Lower extremities	41	38 (92.7)	1.07	0
Hands & feet	19	17 (89.5)	1.11	2 (10.5)

A total of 275 (81.1%) of cases were cleared on the first stage, 5 mm from clinically visible tumor. For all sites, the average number of stages needed to obtain clear margins was 1.26. Cases on the head and neck were less likely to be cleared at 5 mm, with 72.0% of cases cleared on the first stage compared to 89.3% for all other sites ($P < .001$). Patients 70 years and older required an average of 1.37 stages to clear tumor, compared to 1.20 for the rest of the cohort ($P = .023$). There were 3 (0.9%) recurrences, all occurring within 1 year of initial staged excision. Two of the recurrences were on the hands/feet, and one was on the head/neck (Table 1). Three cases were upstaged after the central debulking procedure, with 2 upstaged to T1a (ear and periocular) and 1 case upstaged to T2a (other head and neck). The patient who was upstaged to T2a underwent sentinel node biopsy, the results of which were negative for metastatic disease. At the time of publication, none of the 3 patients with upstaged cases had evidence of recurrent or metastatic disease.

Staged excision techniques are an effective treatment for MIS, resulting in higher clearance rates and lower recurrence rates when compared to wide local excision.[2-5] A significant number of our tumors had subclinical extension requiring larger margins than the 5-mm margins recommended for excision of MIS, especially on the head and neck and in elderly patients. Although more data are needed to generate formalized recommendations regarding staged excision of MIS, data from our single-center study support the growing body of literature suggesting that this is a superior treatment compared to standard excision.

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REFERENCES

1. Johnson TM, Headington JT, Baker SR, Lowe L. Usefulness of the staged excision for lentigo maligna and lentigo maligna melanoma: the "square" procedure. *J Am Acad Dermatol*. 1997;37(5 Pt 1):758-764.
2. Garcia D, Eilers RE, Jiang SB. Recurrence rate of melanoma in situ when treated with serial disk staged excision: a case series. *J Clin Investig Dermatol*. 2017;5(1):1-5.
3. Moyer JS, Rudy S, Boonstra PS, et al. Efficacy of staged excision with permanent section margin control for cutaneous head and neck melanoma. *JAMA Dermatol*. 2017;153(3):282-288.
4. Hazan C, Dusza SW, Delgado R, Busam KJ, Halpern AC, Nehal KS. Staged excision for lentigo maligna and lentigo maligna melanoma: a retrospective analysis of 117 cases. *J Am Acad Dermatol*. 2008;58(1):142-148.
5. de Vries K, Greveling K, Prens LM, et al. Recurrence rate of lentigo maligna after micrographically controlled staged surgical excision. *Br J Dermatol*. 2016;174(3):588-593.

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Use of a dermatology-specific discharge form to improve outpatient follow-up after inpatient dermatology consultation

To the Editor: Inpatient dermatology consultations have been shown to be associated with decreased 1-year readmission rates for patients with inflammatory skin conditions.[1] We anecdotally identified