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Surgical management and practices in pregnancy and lactation: A survey of United States dermatologic surgeons

To the Editor: Treatment of skin cancers in pregnant and lactating women poses a challenge for dermatologic surgeons because the welfare of both mother and fetus must be considered. A standardized approached is especially important because melanoma is a significant cause of cancer-related deaths in women of reproductive age. While guidelines advocate for the immediate surgical management of skin cancers in pregnancy, whether this is applied in practice is unclear.[1,2] To address this knowledge gap, we surveyed members of the American College of Mohs Surgery (ACMS) to describe current practice patterns in the management of malignant lesions in pregnant and lactating women.

Table I. Management of nonmelanoma skin cancer during pregnancy and lactation

Nonmelanoma skin cancer	Treatment rate, %	RR vs 1st trimester	*P* value*
Basal cell carcinoma (n = 117)			
Any form of treatment(s)†			
Timing			
1st trimester	61.5		
2nd trimester	77.8	1.26	.07
3rd trimester	82.1	1.33	<.001
Lactation	98.3	1.60	<.001
Surgical excision			
Timing			
1st trimester	45.3		
2nd trimester	68.4	1.51	<.001
3rd trimester	75.2	1.66	<.001
Lactation	97.4	2.15	<.001
Squamous cell carcinoma (n = 121)			
Any form of treatment(s)			
Timing			
1st trimester	76.9		
2nd trimester	89.2	1.16	.01
3rd trimester	93.3	1.22	<.001
Lactation	99.2	1.29	<.001
Surgical excision			
Timing			
1st trimester	67.0		
2nd trimester	84.3	1.26	.035
3rd trimester	89.3	1.33	.001
Lactation	99.2	1.48	<.001

RR, Relative ratio.
*The *P* value was determined using χ^2 and Fisher exact tests.
†Treatments surveyed: surgical excision, electrodesiccation and curettage, cryotherapy, and topical chemotherapy.

The survey was completed by 123 ACMS members; of whom, 80% of respondents altered practice based on pregnancy and lactation status, and 65.9% did not use epinephrine-containing anesthetics in pregnant vs 26.0% in lactating women ($P < .001$). In addition, 35.8% avoided prophylactic antibiotics during pregnancy. No difference was found in the choice of antiseptic agents, suture strength, or duration of suture placement.

Respondents were significantly less likely to treat basal cell carcinoma, squamous cell carcinoma,

Table II. Surgical excision of melanocytic lesions during pregnancy and lactation

Melanocytic lesion	Treatment rate, %	RR vs 1st trimester	*P* value*
Severely dysplastic nevus (n = 123)			
Timing			
1st trimester	60.2		
2nd trimester	78.9	1.31	.001
3rd trimester	78.0	1.30	.002
Lactation	91.9	1.53	<.001
Melanoma in situ (n = 123)			
Timing			
1st trimester	82.1		
2nd trimester	94.3	1.15	.003
3rd trimester	92.7	1.13	.01
Lactation	96.0	1.17	<.001
Invasive melanoma (n = 123)			
Timing			
1st trimester	95.1		
2nd trimester	98.4	1.03	.28
3rd trimester	96.7	1.02	.75
Lactation	96.7	1.02	.75

RR, Relative ratio.
*The *P* value was determined using χ^2 and Fisher exact tests.

severely dysplastic nevi, and melanoma in situ during the first trimester of pregnancy compared with in later trimesters and lactation (Tables I and II, and Supplemental material, available via Mendeley at https://doi.org/10.17632/jrt4m2nw99.1). In contrast, there was no difference in excising an invasive melanoma in the context of trimester.

Surgeons who performed more procedures per month (>250 [n = 45] vs ≤250 [n = 78]) were more likely to excise basal cell carcinoma (63.6% vs 34.2%, $P = .002$) and severely dysplastic nevi (73.3% vs 52.6%, $P = .02$) in the first trimester. To explore reasons for these choices, we asked participants to rate their degree of concern for pregnancy-related issues that may influence their practice. Fear over legal repercussions, followed by concern of inducing harm to the fetus or infant, were the leading considerations.

There is a recognized growing incidence of skin cancers in women of childbearing age. Our study suggests that pregnancy and lactation status can significantly alter real-world practices. ACMS members who participated in our study were less likely to perform excision and other treatments for basal cell carcinoma, squamous cell carcinoma, severely dysplastic nevi, and melanoma in situ during the first trimester. In contrast, the management of invasive melanoma was not impacted.

Contrary to these preferences, it is important to highlight that the obstetrics literature recommends performing all necessary surgical procedures, regardless of trimester.[3,4] Although it was a significant concern for our respondents, early pregnancy loss or preterm delivery are not significant complications associated with surgical procedures.[4] Guidelines also endorse the use of lidocaine-containing epinephrine.[5]

In summary, timely treatment of melanocytic lesions and nonmelanoma skin cancer is indicated throughout pregnancy. While best available evidence supports the safety of surgical management of skin cancers during pregnancy, plans should be individualized to the patient. Our study is limited by the survey-based design and low response rate (~10% of ACMS members). Further dermatology-specific studies would help to reinforce the safety of skin cancer treatment in the pregnant patient.

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Comparison of different incremental dose regimens of narrow-band ultraviolet B in skin types III to V: A prospective, randomized, single-blind, parallel study in patients with psoriasis

To the Editor: Psoriasis affects approximately 125 million people globally. One of the preferred treatments for psoriasis is narrow-band ultraviolet B (NB-UVB) phototherapy. Although NB-UVB is widely used, there is no consistency between different guidelines regarding the ideal starting dose and the dosage increments. Whereas the European S3 guidelines recommend dosage increments of 30%, the American Academy of Dermatology (AAD) guidelines recommend increments of 20%.[1,2] Although dosimetry needs to be individualized, most phototherapy centers tend to follow regimens recommended in the literature.[3] We aimed to provide relevant recommendations for clinical practice.

We compared the efficacy and safety of three incremental dosage regimens of NB-UVB—10%, 20%, and 30%—in patients with psoriasis with skin types III to V. Patients with psoriasis who met the inclusion criteria were invited to participate in this clinical trial (Supplemental Table I, available via Mendeley at https://doi.org/10.17632/hhs8nrpr8x.1). There were 111 patients randomized to receive different dose increment regimens: group 1, 10%

Table I. Comparison of the rate of erythema

Erythema response 48 h after the last treatment*	Group 1 (n = 49)	Group 2 (n = 48)	Group 3 (n = 11)
0 = none	37 (75.5)	38 (79.2)	3 (27.3)
1 = mild	5 (10.2)	6 (12.5)	1 (9.1)
2 = moderate	4 (8.2)	4 (8.3)	3 (27.3)
3 = severe	1 (2.0)	0 (0.0)	4 (36.3)
Total	10 (20.4)	10 (20.8)	8 (72.7)

Group 1, 10% dose increment; *group 2*, 20% dose increment; *group 3*, 30% dose increment.
Patients who withdrew before first treatment were excluded.
*Data are presented as number (%).

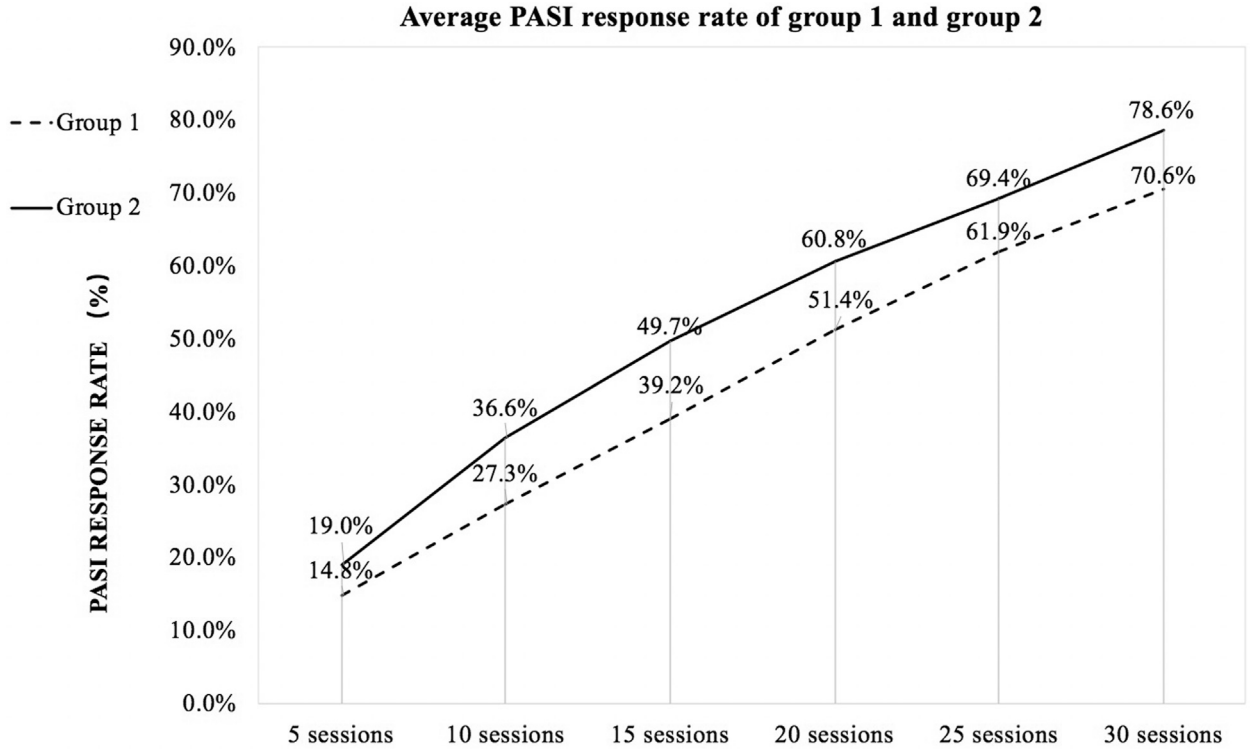

Fig 1. Average Psoriasis Area and Severity Index (*PASI*) response rate of group 1 (10% dose increment) and group 2 (20% dose increment). Nonresponders and patients who withdrew due to adverse effects (n = 5) were included. Determined by repeated-measurement analysis of variance. The degrees of freedom were adjusted by the Greenhouse-Geisser method. $P = .026$.