WPRS
Warrnambool Plastic & Reconstructive Surgery

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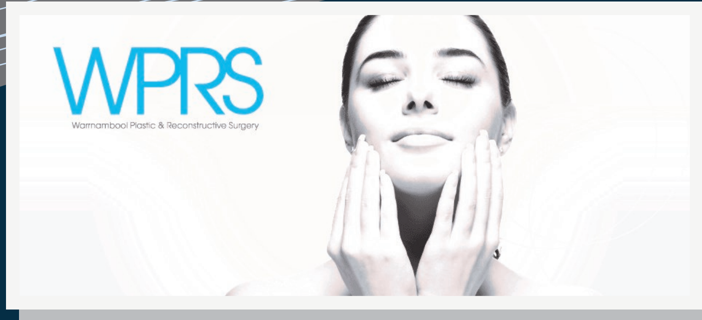
this issue

Let us answer some questions you may have

- What are the causes and management of Gynecomastic?
- Do all Dysplastic neavus need to be excised?



Robert Toma
Warrnambool Plastic & Reconstructive Surgery

Dysplastic neavus: Do they all need to be excised?

Dysplastic neavus or atypical neavus are melanocytic lesions that display atypia both clinically and pathologically. Between 5-10% of Australians will have at least dysplastic neavus, often developing in early adulthood.

Clinically they are often less than 5 mm, irregular in shape, have some variation in pigmentation and often located on sun-exposed areas. However, they are nearly always asymptomatic. Histopathology shows atypical melanocytes in the epidermis with low mitotic rate but no evidence malignant degeneration.

So do they need to be excised? The answer is no. The only reason the remove an atypical lesion is if the lesion is changing (size, colour, shape) or becomes symptomatic (itch and bleeding) to rule out melanoma. The risk of an individual neavus transforming into a melanoma is thought to be 1 in 200,000. In addition, 60% of melanomas develop with no precursor lesion. Therefore, removing individual neavus does not change the lifetime risk of developing melanoma.

So what is the significance of dysplastic neavus? If patients have more than 5 neavus then there relative risk of developing melanoma is increase by 5 to the rest of the population. Hence, these patients need more regular skin reviews and education on signs to look out for regarding melanoma.

FAMM (familial atypical mole and melanoma) is a condition where people have more than 50 atypical neavus with one or more family members with melanoma. These are very high-risk patients with relative risk of developing melanoma ranging between 22-247. These patients need very close surveillance

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Telephone: (03) 5562 5330

Gynecomastia: causes and management

Gynecomastia is benign enlargement of male breast tissue due to glandular proliferation. It is usually bilateral, however can be unilateral. It needs to be differentiated from psudo-gynecomastia (Lipomastia), which is due to fat accumulation.

Peak incidence is during puberty (up to 60%) and during old age (24-65%). It often presents with a rubbery firm enlargement around the nipple, with discomfort a common symptom. Social embarrassment and pain are often reasons for presentation.

Pubertal gynecomastia will often resolve within 18 months and nearly all resolve by 17 years old. Hence conservative management of often recommended.

Although idiopathic gynecomastia is the most common cause, it is important to rule out secondary causes. Important things to check for are:

1. Breast cancer- if unilateral/asymmetrical enlargement an US or mammogram should be performed.
2. Estrogen/testosterone abnormality- levels should be checked in anyone with suggestions of developmental delay or sexual dysfunction. If these levels are abnormal they require further investigation of there adrenals.
3. Testicular cancer- important to rule out in any case of gynecomastia. Perform an US if in doubt.
4. Drug use: in particular marijuana. Although many prescription medication can also cause gynecomastia

Surgical intervention is usually undertaken once secondary causes are ruled out. Surgical options range from liposuction for mild cases to formal breast reduction for more advanced cases

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