WPRS
Warrnambool Plastic & Reconstructive Surgery

Issue
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# this issue

Let us answer some questions you may have

- To curette or excise? What is best way to remove skin lesions?
- Arthritis of the first CMCJ: What is the best management ?

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## To curette or excise? What is the best way to remove a skin lesion?

A lady presents to your practice wanting an intra-dermal naevus removed from her chin. What is the best way to remove this? The answer is: excision. Why?

Curetting of lesions has gained some popularity over the last few years. The perceived benefit is that a lesion can be removed and once the wound has healed there will be no scar. This is however only partially true. The curetted area will be pale compared to the surrounding skin and this can sometimes be harder to hide on the face then a small scar from excision. In addition, pathologist cannot comment on margins of excision or provide an accurate diagnosis due to the absence of tissue architecture. Also the recurrence rate of lesions is higher with curetting. So which lesions would I curette?

Seborrheic keratosis and solar keratosis are the only two.
Personally, I do not curette SCC, SCC in situ, BCC and any pigmented lesion in my practice as it is not safe, nor recommended by the NHMRC guidelines.

In terms of cosmesis, excision and direct closure can provide results that are equivalent, if not better then curetting. The post- operative management of the scar is extremely important in order to obtain these results. At WPRS, we recommend taping of the scar with brown micropore tape for 6 weeks and then massage of scar with sorbolene cream for 6 weeks.

www.wprs.net.au

## Arthritis of the first CMCJ: what is the best management?

The first carpometacarpal joint (CMCJ) is the most commonly affected joint of the hand with osteoarthritis. It is particularly common in women with symptoms often beginning around the age of 50. Considering the thumb contributes 50% of hand function this condition can be very debilitating for the patient.

The most common symptom is pain at the 1st CMCJ. Hand strength is also decreased with patients finding the opening of jars particularly difficult.
Signs include:

- Pain on palpation in anatomical snuff box
- Shoulder sign (prominent base of 1st metacarpal due to subluxation)
- Z- deformity of thumb (Flexion of MCPJ and extension of DIPJ of thumb to compensate for subluxation of 1st CMCJ)

An x-ray of the first CMCJ is the most important investigation. Not only will it determine the extent of the disease it will also guide treatment. Eaton-littler classification is based on the x-ray and depending on the grade as to the course of treatment that will be most successful.
Grade 1: CMCJ joint space widening only
Grade 2: osteophytes, subchondral sclerosis and CMCJ narrowing
Grade 3: above + trapezial OA
Grade 4: Above + pantrapezial OA

With grade 1 and 2, it responds well to splinting and steroid injection. I use US guided injection as I find it more reliable. You can inject a joint up to 3 times before it becomes unsafe. Grade 3 and 4 patients have less benefit from steroid and are better managed operatively. The most common operation performed is trapeziectomy and tendon re-suspension which is the operation I recommend.

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## ...CHRISTMAS CLOSURE...

Would you please note that our rooms will be on leave from :

Close of business - **Friday 21st December 2012** until **Friday 4th January 2013** - Inclusive.
The rooms will reopen as normal on **Monday 7th January 2013.**

**We wish you a Merry Christmas and a safe and Happy New Year.**