Report From Hugh Greenway's 30th Annual Superficial Anatomy and Cutaneous Surgery, 2013

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Kari Nielsen had the opportunity to attend the above-mentioned training course in surgery in La Jolla, California, USA with the help of a scholarship. Below she informs about her experiences during this course and tells us about the value of such a course.

I had the pleasure to receive the 2013 SDKO (*Svenska Sällskapet för Dermatologisk Kirurgi och Onkologi*) Education Scholarship, which was a great honour. I would like to take the opportunity to thank for the scholarship and tell about all the things I experienced as a recipient.

I used the scholarship to attend the surgery course in La Jolla, California, which I had heard a lot about from previous SDKO Scholarship recipient, Helena Gonzalez, who attended the course in 2012[1]. A preview of the 2013 programme promised an intense few days with a combination of theoretical and practical surgical modules. On site, all my expectations of a well-planned course with renowned lecturers, some of whom had been involved in the course since its start 30 years ago, came true.

Despite the packed schedule there was always time for questions and reflections during the classes. We started early in the mornings and usually did not finish until 10.30 p.m. The evenings were often spent discussing the courses and lectures that were specifically held for the American residents who were taking their board exams after the course. Although this was not mandatory for us it was interesting to hear what they were expected to master, which was both detailed pre-clinical skills and more clinical dermatological techniques.

The highlight of the course was to practise the surgical methods we had just been taught with supervision. It is much easier to apply new surgical knowledge when one has had the opportunity to practise operating on real skin instead of artificial skin. The donated bodies were shown great respect in the operating theatre and it was just like an authentic surgery on patients. In these surgical demonstrations we were divided into groups of mixed nationalities and surgical experience. We had a great exchange of knowledge and ideas in my group and I am sure the other groups experience the same. During these surgical tutorials supervisors also demonstrated anatomy and different surgical techniques, such as transplants and flap surgery. The lab manual that was handed out contained a detailed list of the aims for each day, for example rotational flaps, bilobed flaps, ear cartilage harvest and facial nerve dissection. The background knowledge of the group members and expectations of the course determined what we focused on along with the field of expertise of the supervisors, when real-life surgeries were performed. To operate together with others also made me contemplate whether one can improve the running of our own clinic. Seeing how others work can sometimes be an eye-opener and can inspire improvements or make you appreciate your clinic as it is. I also thought it was rewarding to take the course together with a colleague from my own clinic, as it is easier to discuss and carry out changes in management if you have similar experiences.

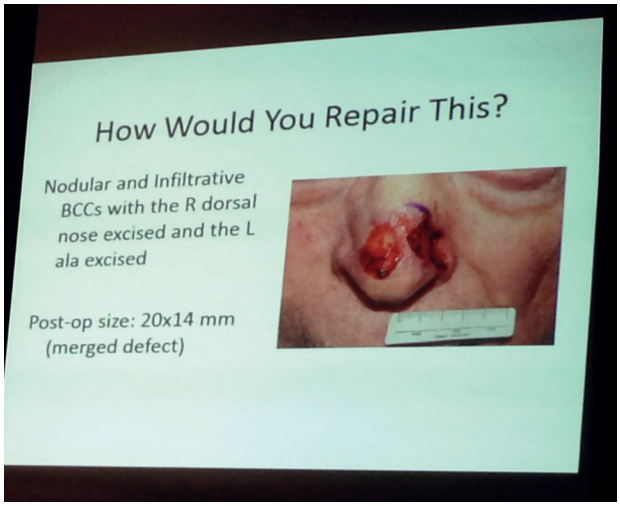

Fig. 1. This is an example of our team work; to learn how to decide which techniques would be best.

Gonzales H. 29th Annual Superficial Anatomy and Cutaneous Surgery Course, La Jolla, California, USA. Forum for Nord Derm Ven 2013; 18: 25–26.

Fig. 2. Kari Nielsen (*left*), together with some of the other Swedish participants, Daniel Brännström (Helsingborg) och Irina Baranovskaya (Malmö).

Another excellent module was the theoretical training in various clinical case studies. The supervisor presented tumour cases and it was up to us to suggest surgical solutions. We had many discussions about pros and cons with different flap surgeries, but we often also suggested secondary healing.

One observation, which I and the other Swedish participants made was that it more or less always was assumed, often unrelated to tumour aggressiveness, that Mohs micrographic surgery was provided as the primary surgical choice. That is not the standard in Sweden, where we only have 3 hospitals where Mohs micrographic surgery is available, dealing with the most advanced types of tumours. The advantage when Mohs surgery is performed primarily, and one knows that the primary defect is 100% tumour free, is that one can easily choose which wound closure technique to use (i.e. flaps/grafts) without risking that any residual tumour is left under the flap. Without Mohs surgery is it impossible to know whether complete tumour clearance has been achieved until one has got the path report (the PAD), i.e. the histological examination of the tumour made by a pathologist, which usually takes one to several weeks. Hence, without Mohs surgery available as the primary technique it is better to close a defect with a different technique than a flap or a graft and that is so far the clinical situation for most surgically interested Swedish dermatologists. Because the US payment system for surgical procedures is so different from the system in Sweden it was hard to understand the reasoning behind performing unnecessarily complicated procedures to obtain adequate surgical radicality and a cosmetically appealing result.

Perhaps in the future more Mohs surgical centres will be built in Sweden, and everyone working there would benefit from attending this course. Overall, I thought it was a very rewarding course and I can truly recommend it to colleagues. If it had been possible I would have liked to reattend the course in a few years, or to take a similar European course to repeat techniques and acquire further surgical skills.

English translation: Hanna Norsted