Letter to the Editor

Peripheral Excision Margins for Dermatofibrosarcoma Protuberans

To the Editor:

A letter by Zager et al.¹ referencing our article² raises two concerns, which we would like to address. The first is that the series we present includes widely divergent excision margins, the provenance of which is said to be unclear. To this, we respond that the margins are not disparate wide excision margins chosen arbitrarily but rather the computed posttreatment margins after Mohs micrographic surgery. Mohs surgery undertakes removal of cutaneous tumors by a stylized method of staged excision; for dermatofibrosarcoma protuberans (DFSP), typically 5 mm are removed beyond the clinically apparent margins, and frozen section analysis is performed on the periphery. Positive margins are mapped, and another 5 mm is taken at the involved sites. The process continues until peripheral margins are cleared. Our purpose was not to validate or recommend Mohs surgery, but rather to use the measured final defects after Mohs as a proxy for true tumor width. In that DFSPs removed by Mohs were excised in a staged manner, final wound defects would be within 5 mm of the true tumor extent. Comparison of the preoperative tumor size to the true tumor extent, as determined by the method outlined above, then provided the grist for this paper, and the conclusion that DFSPs are often much wider than they appear to a trained clinical eye.

The second concern is that the method we propose for removal of DFSPs may not be necessary. Specifically, they describe their experience with wide local excision, followed by re-excision if positive margins are detected on permanent section. They note the high cumulative cure rates offered by their approach. DFSP is a challenging tumor, and it is useful for clinicians be able to select from a variety of validated approaches for its successful removal. That being said, the reason we developed our method of intraoperative Mohs for peripheral margins followed by deep margin excision was to minimize the need for reoperation for positive peripheral margins. Intraoperative frozen section assessment is tissue sparing; because the lateral edge of each margin is checked before the patient is discharged, narrow margins can be taken without concern that tumor will be

left behind. Moreover, intraoperative frozen section assessment offers a high likelihood of tumor clearance with the first excisional procedure; because margins are histologically checked en face, the likelihood that a subsequent procedure will be needed to remove residual peripheral tumor is reduced. Thus, we like our method because it minimizes the final wound defect; maximizes the aesthetics and function of the repair; and reduces the risk that definitive tumor clearance may necessitate a second procedure, with the attendant inconvenience to the patient, cost, and potential morbidity.

The research of Zager et al. adds substantially to the slim body of work on treatment of DFSP. We believe that our approach has the benefits we describe. And yet we also believe that the optimum approach may not always be the same. The best way to treat a particular DFSP may be contingent on the resources available at a given institution; the prior experience of that institution; and the individual physician and patient's decision-making regarding the relative importance of factors such as cost, speed, and risk of reoperation. Clearly, there are many ways to skin a DFSP.

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