

Considering the role of shave excision in early melanoma diagnosis

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Background and objective

Shave excisions are increasingly used in Australian clinical practice for melanoma diagnosis, yet concerns persist regarding margin involvement, diagnostic accuracy and cosmetic outcomes. This study assessed clinician perspectives on the estimated costs, logistics and outcomes of shave versus elliptical excision for melanoma diagnosis.

Methods

An anonymous online survey was distributed to 229 Australian general practitioners and dermatologists involved in skin cancer management. Data on procedure setting, equipment, follow-up, costs and clinical perceptions were analysed.

Results

Clinicians reported shave excision as faster and less resource-intensive than elliptical excision, with higher rates of same-day procedures and reduced follow-up. Median estimated total cost per procedure was \$753 for shave excision versus \$1473–\$1504 for elliptical excision. Users reported favourable cosmetic outcomes and low incidence of deep margin involvement when performed appropriately.

Discussion

Shave excision is likely a cost-saving, diagnostically reliable method for selected lesions. Further prospective research and guideline updates are warranted.

AUSTRALIA HAS THE HIGHEST melanoma incidence globally.¹ Early diagnosis is associated with improved prognosis and less extensive treatment, as thinner melanomas have a significantly lower risk of metastasis and mortality when compared with thicker lesions.² Commonly used diagnostic methods include elliptical excision, shave excision and partial biopsies.² Where possible, complete removal of the lesion is advised to enable accurate histopathological assessment. Partial sampling techniques should generally be avoided, as they risk missing invasive components. Current Australian guidelines recommend elliptical excision with narrow margins as the optimal biopsy technique for suspicious pigmented lesions. However, these recommendations are supported by Level C evidence only (ie the body of evidence provides some support for recommendation/s, but care should be taken in its application).² Shave excisions are suggested for lesions suspicious for early melanomas.²

Both shave excision and elliptical excision are used with the intent of complete lesion removal, and each has a place in the management of lesions suspicious for melanoma.² The choice of technique should be guided by lesion characteristics, clinician expertise and patient preferences. Although technically simple, effective shave excisions require adequate training in lesion selection and surgical technique. Shave excision is increasingly used in Australian clinical practice, with utilisation more

common among specialist dermatologists.³ Concerns around base transection, histological accuracy and cosmesis are raised by some.^{4–6} Recent evidence suggests these concerns are likely unfounded given appropriate clinician training, lesion selection and surgical technique.^{5,7–10} We argue that shave excision is a valid and efficient diagnostic method for thin melanomas, and we summarise key advantages and commonly cited criticisms of shave excision in Table 1.

The aim of this study was to assess clinical practice patterns and perceptions related to shave excision versus elliptical excision for early melanoma diagnosis, and to compare estimated procedural costs. The primary objective is to compare the estimated direct and indirect costs associated with each procedure on the basis of real-world clinician input. Shave excision is thought to be less costly, but this has not been well studied. We hypothesised it would be associated with lower costs, reduced equipment use, fewer follow-up visits and high clinician satisfaction when used appropriately.

Methods

We used a cross-sectional descriptive study employing an anonymous online survey to investigate clinician practice patterns, procedural logistics and cost differences between shave excision and elliptical excision for the diagnosis of early melanoma.

An exemption from full ethics review was granted by the Mater Misericordiae Human

Table 1. Advantages and criticisms of shave excision in thin lesions suspicious of melanoma diagnosis

Advantage of shave excision when compared with elliptical excision	Evidence-based response
Same-day procedure	Facilitates faster diagnosis, reduces anxiety, increases patient compliance ⁸
Quick and efficient	Takes less time to perform, requires less setup ^{11,12} Facilitates multiple procedures at the same visit ¹³
Minimal equipment	Typically requires only plain lignocaine, scalpel, gauze and dressing ^{9,12}
Tissue-conserving	Useful for small or cosmetically sensitive lesions ^{12,13}
Rapid turnaround of results	Enables early intervention, which reduces patient anxiety ^{7,8,10}
Common criticism	Evidence-based response
Risk of base transection	Extremely rare when performed by skilled clinicians with appropriate lesion selection and technique ^{5,7}
Lower diagnostic accuracy	Equivalent accuracy to elliptical excision in multiple studies ^{9,10}
Re-excisions are larger	Theoretical only, of little importance on trunk and limbs; most initial excisions are benign and not re-excised ^{6,12}
Poor cosmetic outcomes	In survey data, 80% clinician satisfaction with cosmetic outcomes; ¹³ ellipse remains a revision option if needed

Research Ethics Committee (Project ID: 115860), in accordance with section 5.1.17 of the National Statement on Ethical Conduct in Human Research (2023).

The survey instrument was developed by the research team, which comprised a specialist dermatologist, prevocational dermatologists and a health economist. The survey focused on the diagnostic management of clinically suspected thin melanoma lesions, where either shave or elliptical excision would be considered acceptable approaches. Survey content was informed by relevant literature, clinical guidelines and procedural experience. Content validity was assessed through expert review, and the instrument was piloted internally to ensure clarity and relevance. The final version consisted of multiple-choice and Likert scale questions, with one free-test response option. The complete survey is provided as Appendix 1 (available online only).

Participants were Australian general practitioners (GPs) and dermatologists engaged in skin cancer diagnosis and management. Distribution occurred via email through three professional organisations: the Australasian College of Dermatologists, the Skin Cancer College Australasia, and the Australian College of Rural and

Remote Medicine. Survey invitations were disseminated with organisational approval through their respective member mailing lists. The survey was open from 10 March to 30 March 2025. GPs without additional skin cancer qualifications were not included, which may limit generalisability.

Responses were collected using Qualtrics and exported to SPSS (Version 29, IBM Corp) for analysis. Only fully completed responses were included. Data were analysed descriptively. Cost estimates were calculated by combining clinician-reported resource use with publicly available pricing data, including Medicare Benefits Schedule (MBS) rebates, medical equipment supplier pricing, and indirect cost estimates such as lost productivity sourced from WorkSafe Australia reports.

Results

A total of 229 completed responses were received. Although a response rate could not be calculated, the number of responses (n = 229) is comparable to other published survey studies involving clinician participants.^{5,11–14} Most respondents were GPs with formal skin cancer qualifications (n = 119, 52%) or dermatologists (n = 96, 42%). Most participants had more than

10 years of clinical experience in skin cancer management (n = 165, 72%) and reported at least half of their clinical workload involved skin cancer-related activity (n = 195, 85%).

Clinicians were more likely to remove a lesion at the same appointment with a shave (n = 194, 85%) versus elliptical excision (n = 39, 17%). Clinicians were more likely to defer elliptical excisions to a subsequent visit and to perform multiple procedures in a single visit when using shave excision when compared with elliptical excision. Among respondents who reported encountering patients with multiple skin cancers (n = 92), 40% stated they would ‘often’ or ‘always’ perform more than two procedures in the same appointment.

Follow-up requirements also differed by procedure. Only 7% (n = 16) of respondents ‘always’ required a follow-up appointment after shave excision, compared with 98% (n = 293) following elliptical excision with external sutures. Clinicians also reported advising physical activity restrictions far more frequently after elliptical excisions (85%, n = 254 ‘often’ or ‘always’) than after shaves (7%, n = 20).

Clinicians typically reported using minimal equipment for shave excisions — primarily local anaesthetic, a scalpel, haemostatic agent, gauze and a basic dressing. In contrast,

Table 2. Cost comparison between shave excision and elliptical excision for melanoma diagnosis

	Direct healthcare costs	Other direct costs	Indirect costs	Total cost
Shave excision	Skin check encounter ^A = \$64 Skin biopsy (MBS item number 30071) = \$59.50	Equipment: \$4.05 Of the 142 respondents using shave excision, n = 114 (80%) respondents used these items for this procedure: Local anaesthetic (\$1.50) + scalpel blade (\$0.50) + gauze (\$0.50) + haemostatic solution (\$1.25) + dressing (\$0.30) = \$4.05 ^B	Practice costs per patient per visit ^C = \$55.55 Patient costs per visit: ^D per day work absenteeism/reduced productivity = \$570	Total direct cost (estimate): \$127.55 Total indirect cost (estimate): \$625.50 (one visit) Total cost: \$753
Elliptical excision	Skin check encounter ^A = \$64 Excision (other than shave) of clinically suspected melanoma (MBS item number 31377–31379) = \$124.90–\$152.60	Equipment: \$44.80 Of the 162 respondents using elliptical excision, n = 147 (91%) respondents used these items for this procedure: Lignocaine with adrenaline (\$2.80) + dressing pack (\$1.30) + suture pack (\$18) + drape (\$3) + electrocautery (\$5.26) + suture absorbable (\$9.70) + suture non absorbable (\$4.10) + dressing (\$0.70) = \$44.80 ^B	Practice costs per patient per visit ^C = \$55.55 Patient costs per visit: ^D per day work absenteeism/reduced productivity = \$570	Total direct cost (estimate): \$222–\$253 Total indirect cost (estimate): \$1251 (two visits) Total cost: \$1473–\$1504

^A Average cost for MBS Codes 3, 23, 36, 44, 52, 53, 54, 57, 701, 703, 705, 707, 5000, 5020, 5040, 5060, 10990, 10991, 10997 (Professional attendance at consulting rooms by a general practitioner or specialist).

^B Equipment prices sourced from <https://nationalsurgical.com.au/home> and www.amaproducts.com.au/home.

^C Empirical estimates to account for all practice capabilities needed for the delivery of comprehensive care based on published data from the US.¹⁸ No Australian data are available.

^D Based on an Australian figure from WorkSafe Queensland (www.worksafe.qld.gov.au/_data/assets/pdf_file/0020/154181/Private-Hospital-Services-Table-of-Costs-5-December-2025.pdf).

MBS, Medicare Benefits Schedule.

elliptical excision required more extensive setup, including sterile suture packs, drapes, absorbable and non-absorbable sutures, and electrocautery in most cases (Table 2).

In the MBS, elliptical excisions are billed under items 31377–31383, with rebates ranging from \$124.90 to \$152.60. Importantly, the wording for MBS items 31377–31383 excludes shave excision from these higher melanoma-specific billing categories. Shave excisions are billed as a biopsy under item 30071 with a rebate of \$59.50, a saving when compared with elliptical excision of \$65.40–\$93.10 per procedure.

Combining direct and estimated indirect costs (including a work absenteeism estimate of \$570/day¹⁵), the estimated total cost of a shave excision is approximately \$753, compared with \$1473–\$1504 for elliptical excision (Table 2). The cost differential is driven by reduced need for follow-up and time away from work for shave when compared with elliptical excision.

Approximately half (n = 119, 54%) of survey respondents reported employing shave excisions for pigmented lesions suspicious for in situ or thin melanoma. In free-text responses, commonly cited advantages for shave excisions over elliptical excisions included ease of performing the procedure during the same consultation, minimal equipment, reduced follow-up visits, improved workflow efficiency and high patient acceptance (Table 3). Regular users of shave excision reported that margin involvement was not a significant issue when employing appropriate lesion selection and technique.

Clinicians who avoided shave excision (19% reported ‘never’ using) listed perceived suboptimal cosmesis, high risk of base transection and diagnostic uncertainty due to incomplete sampling. Some noted a lack of training or confidence in their ability to perform the technique optimally (Table 3). Apprehension about deviating from clinical guidelines recommending elliptical excision

for suspected melanoma was cited as a reason to avoid shave excision. The influence of guidelines on clinical practice in our sample was mixed, with 30% (n = 65) stating the guidelines around the use of elliptical excision were ‘very influential’ on their practice, while 20% (n = 45) indicated they were ‘not influential’. Responding specialist dermatologists were supportive of shave excision, citing comprehensive training in dermoscopy, lesion assessment and procedural techniques as factors enabling confident use. GPs were more likely to never or rarely employ shave excision.

Discussion

Our findings show that shave excision, when used appropriately, is associated with lower procedural costs, reduced equipment needs and fewer follow-up visits when compared with elliptical excision, as well as high clinician acceptability. Despite these benefits, clinician views remain divided,

Table 3. Surveyed ‘pros and cons’ of shave excision

Examples of respondents listing ‘pros’ of shave excision	Examples of respondents listing ‘cons’ of shave excision
‘For the right lesions in experienced hands, it is quick, easy and cost effective.’	‘Given the amount and type of equipment used, I do not find shave excisions to represent a significant time saving compared with elliptical excisions.’
‘Simple, minimal complications, accurate, minimal patient impact, quick.’	‘Shave excisions make a huge mess, hideous scars, and histology specimens often not good enough.’
‘I think it is affordable and time-saving solution compared to elliptical excision and should be used frequently.’	‘I really don’t do these for pigmented lesions. The local pathologists really don’t seem to like it.’
‘Unfathomable to consider a severely sun-damaged patient having no access to shave excision for practical reasons, clinical imperative, clinical urgency and particularly for patient convenience/safety.’	‘I find shaves useful though find them difficult legally to defend because of the melanoma guidelines.’

with some expressing concerns about histological accuracy, cosmetic outcomes, and medico-legal risk associated with deviating from existing clinical practice guidelines.

Shave excision is often conflated with shave biopsy,¹⁴ a superficial sampling technique, rather than attempted complete excision. When performed with the intent to fully remove a lesion, shave excisions provide adequate tissue for histological assessment and accurate diagnosis. Shave excision of a lesion where melanoma is a significant differential should only be performed when the clinician is confident it can be safely and completely removed in width and depth. Recent prospective Australian data of over 300 shave-excised pigmented lesions, including 50 melanomas, found no deep margin transection when performed by trained clinicians.⁷ Lateral margin involvement was equivalent to elliptical excision. While elliptical excision allows for easier specimen orientation, this is generally not a limiting factor in shave excision, as definitive management typically involves subsequent wide local excision.

Shave excision yields a higher proportion of in situ melanomas than invasive, suggesting that it may facilitate earlier detection.^{12,13} A recent review found no significant difference in diagnostic accuracy or margin involvement of shave when compared with elliptical excision.⁹ Further, 80% of dermatologists and GPs who regularly used shave excision were satisfied with the cosmetic results.¹³ Concerns about scarring apply to both shave and elliptical procedures. No studies have specifically

asked patients about their satisfaction with cosmetic outcomes following shave versus elliptical excision, representing an important area for further research.

The ability to promptly remove multiple suspect lesions may help alleviate patient anxiety by ensuring that potentially cancerous lesions are addressed without delay and can be sent for histopathological assessment sooner. Our survey revealed that elliptical excision is uncommonly a same-day procedure, in contrast to shave excision. Rescheduling procedures to another day places a logistical and medico-legal burden on practitioners.¹⁴ Compliance is virtually guaranteed with same-day shave excision. Further research exploring patient perspectives on shave and elliptical excision could provide valuable insights and help inform future clinical recommendations.

Skin cancers collectively impose the highest economic burden of all cancers on the Australian healthcare system.^{16,17} As the diagnosis of skin cancer, particularly thin and in situ melanoma, continues to increase in Australia, it is essential to evaluate the economic impact of diagnostic procedures. Identifying cost-saving methods that do not compromise clinical care can help mitigate financial burdens in a resource-restrained healthcare system and ensure more sustainable healthcare practices. We have shown that shave excisions are likely a cost-saving diagnostic method when compared with elliptical excision. The cost estimates were based on clinician-reported practice patterns, including follow-up visits, and applied consistently across

both procedures using uniform sources for comparison. Result discussions following shave excision were commonly conducted remotely, with no follow-up visit required in the majority of cases.

From a national perspective, 15,628 melanomas were diagnosed in Australia in 2019.¹⁶ Using the results from a Queensland cohort,³ 67% of these melanomas were melanoma in situ (n = 10,471). Of the remaining invasive melanomas (n = 5157), 69% were <1 mm in thickness (n = 3559). The majority of in situ and thin invasive melanomas diagnosed in Australia could have been initially managed using shave excision. Had the estimated number of in situ or thin invasive melanomas (approximately 14,029 cases) diagnosed in Australia in 2019 been managed with shave excision, the total cost would be approximately \$10.5 million, based on our estimated cost of \$753 per procedure. In contrast, management with elliptical excision at a cost of \$1473–\$1504 per case would produce estimated total costs of \$20.6–\$21.1 million. Widespread shave excision use represents a potential cost saving of approximately \$10–11 million annually. Given the assumptions of our cost estimates, these values should be interpreted with caution until more detailed costing studies are performed.

This study has limitations. The survey was based on self-reported practices, which are subject to bias. However, self-reported responses allowed us to highlight the opposing views of Australian clinicians on the use of shave excision in clinical practice. Out-of-pocket costs were not included in

our analysis because of their variability and the difficulty in obtaining reliable data. We also acknowledge that the use of a full day of work absenteeism for follow-up visits may overestimate productivity loss in some cases. Our costings were based on estimated values, with more detailed costing studies required to better quantify the total costs for shave and elliptical excision procedures.

Cost is only one consideration among many in melanoma diagnosis, and further studies assessing patient outcomes will be critical to complement economic findings. We also acknowledge that lesion-specific factors such as anatomical site may influence the choice of biopsy technique, cost and clinical outcomes. However, our study was designed to assess broader patterns in clinical practice.

Despite benefits in terms of cost and time savings and demonstrable safety, a proportion of Australian clinicians remain reluctant to perform shave excisions. This may be driven by current Australian melanoma guidelines, which recommend elliptical excision for initial diagnosis on the basis of Level C evidence only. Current clinical guidelines should be updated to reflect the widespread and increasing use of shave excision and the ample data supporting its relative utility, efficiency, lower cost and safety.

Conclusion

Shave excision is increasingly and effectively used in clinical practice, particularly among specialist dermatologists. Our real-world data highlight the practicality of shave excisions, including the ability to perform procedures on the same day with minimal equipment requirements, a reduced need for follow-up appointments for wound management or suture removal, and a reduction in both estimated direct medical costs and indirect costs such as time off work when compared with elliptical excision. Shave excision also facilitates the treatment of multiple lesions in a single visit, an important consideration in a region with the highest incidence of skin cancer in the world. Given the available evidence and positive views of regular users of shave excision, familiarisation with and training in the technique may dispel the concerns of those who rarely or never employ shave excisions, particularly among GPs.

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Appendix 1

This Appendix is published as supplied and is unedited by *AJGP*.

What is your qualification (or current training pathway)?

- ☐ FACD
- ☐ FRACGP
- ☐ FRACGP + Certificate/Diploma/Masters in Skin Cancer or equivalent further training
- ☐ FRACS
- ☐ FACRRM
- ☐ FACRRM + Certificate/Diploma/Masters in Skin Cancer or equivalent further training
- ☐ Other (please specify) _____

How many years have you been working in the field of skin cancer diagnosis and management?

- ☐ 0-1
- ☐ 2-5
- ☐ 6-10
- ☐ 11-20
- ☐ >20

What fraction of your daily workload is skin cancer management?

- ☐ All of my workload is skin cancer management
- ☐ The majority of my workload is skin cancer management
- ☐ Approximately half of my workload is skin cancer management
- ☐ The minority of my workload is skin cancer management
- ☐ None of my workload is skin cancer management

How many skin surgery procedures do you perform on average on a typical consulting day when doing skin checks (as opposed to a booked surgical list)?

- ☐ 0
- ☐ 1-5
- ☐ 6-10
- ☐ 11-15
- ☐ >15

The Australian Cancer Council guidelines state the following regarding the diagnosis of melanoma: 'The optimal biopsy approach for a suspicious pigmented lesion is complete excision with a 2 mm clinical margin and upper subcutis'.

How influential is this clinical guideline statement to your clinical practice and initial diagnostic procedure choice for managing a suspicious pigmented lesion?

- ☐ Very influential
- ☐ Moderately influential
- ☐ Slightly influential
- ☐ Not influential
- ☐ Unsure/ not applicable

The Australian Cancer Council guidelines also state the following regarding the diagnosis of melanoma: ‘Deep shave excision (saucerisation/scoop) and punch excision methods might also be used for complete excision but are more often associated with positive margins than elliptical excision with primary closure.’

How influential is this clinical guideline statement to your clinical practice and initial diagnostic procedure choice for managing a suspicious pigmented lesion?

- ☐ Very influential
- ☐ Moderately influential
- ☐ Slightly influential
- ☐ Not influential
- ☐ Unsure/ not applicable

If presented with a <1cm diameter pigmented lesion on the trunk or limbs where your differential diagnosis included dysplastic/atypical naevus, in situ or at worst early invasive melanoma where you felt initial excision with narrow margins was indicated, how often would you use the following procedures?

	I do not perform this procedure in my clinical practice	Never	Infrequently	Sometimes	Often	Always
Shave excision	☐	☐	☐	☐	☐	☐
Elliptical excision	☐	☐	☐	☐	☐	☐
Partial biopsy	☐	☐	☐	☐	☐	☐

How often do you advise restriction in physical activity following an elliptical excision?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Infrequently
- ☐ Never

Typically, following an elliptical excision with external sutures, a follow up appointment is needed 5-14 days after for removal of sutures (which is separate to follow up for histology results). How often do you require a similar follow up appointment following the procedures below?

	I do not perform this procedure in my clinical practice	Never	Infrequently	Sometimes	Often	Always
Shave excision	☐	☐	☐	☐	☐	☐
Elliptical excision where only internal sutures were used	☐	☐	☐	☐	☐	☐
Elliptical excision where external sutures were used	☐	☐	☐	☐	☐	☐

How often would you do multiple procedures (>2) on this patient at the same appointment these were found?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Infrequently
- ☐ Never

Which procedure(s) are you most likely to use for managing this patient (select all that apply)?

- ☐ Biopsy (punch or shave)
- ☐ Curettage
- ☐ Shave excision
- ☐ Elliptical excision
- ☐ A combination of these
- ☐ None of these
- ☐ Not applicable to my clinical practice

How often would you defer these procedures to another day (instead of performing them on the same day they were detected)?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Infrequently
- ☐ Never

What equipment do you typically use when performing the following procedures (select all that apply)?

	Shave excision	Elliptical excision
Local anaesthetic without adrenaline	☐	☐
Local anaesthetic with adrenaline	☐	☐
Dressing pack (disposable pack with a combination of plastic tray, dressing towel, forceps, gauze swabs, gauze balls, scalpel and a sterile 'window' drape)	☐	☐
Reusable surgical equipment that needs autoclaving	☐	☐
Sterile suture pack (disposable)	☐	☐
Drape kit (disposable sterile drapes)	☐	☐
Electrocautery	☐	☐
Topical haemostatic agent (e.g. silver nitrate, zinc chloride)	☐	☐

Absorbable sutures	☐	☐
Sutures that need removal	☐	☐
Skin glue (e.g. dermabond, histoacryl)	☐	☐
Occlusive dressing (e.g. tegaderm, opsite, mepilex)	☐	☐
I do not perform this procedure in my clinical practice	☐	☐
Other (please specify)	☐	☐

Restriction in physical activity that impacts work ability and day to day living activities is often advised by practitioners following skin procedures. How often do you advise restriction in physical activity following a shave excision?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Infrequently
- ☐ Never

How often do you advise restriction in physical activity following an elliptical excision?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Infrequently
- ☐ Never

Typically, following an elliptical excision with external sutures, a follow up appointment is needed 5-14 days after for removal of sutures (which is separate to follow up for histology results). How often do you require a similar follow up appointment following the procedures below?

	I do not perform this procedure in my clinical practice	Never	Infrequently	Sometimes	Often	Always
Shave excision	☐	☐	☐	☐	☐	☐
Elliptical excision where only internal sutures were used	☐	☐	☐	☐	☐	☐
Elliptical excision where external sutures were used	☐	☐	☐	☐	☐	☐

How do you most commonly communicate the histology results to the patient (regardless of the procedure used)?

- ☐ Mobile text message
- ☐ Phone call
- ☐ Telehealth video consult
- ☐ Face to face appointment

Please leave any comments you have about the use of shave excisions in clinical practice in the text box below.