

the elbow segments of the ulnar nerves, with the right side slightly more affected.

We observed that cranking the espresso machine's arm involved repeated elbow flexion to 90 degrees against the resistance of the crank arm. This arm position has been previously reported to compromise the ulnar nerve at the elbow due to narrowing of the cubital tunnel.<sup>2</sup> We advised the espresso maker to consider an automated machine, which he purchased. His symptoms of "espresso elbow" gradually resolved, and repeat nerve conduction study results were normal. We are in agreement with Dr Shusterman's conclusion that the appropriate application of alternative work practices can keep workers healthy and, in this case, physicians alert and oriented for morning rounds.

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## Clarification

To THE EDITOR: In reading our paper "Pleuropulmonary Manifestations of Hepatic Amebiasis" in the September issue,<sup>1</sup> I noted some editing changes that inadvertently changed the meaning of some of the sentences.

The first sentence of the abstract was edited to read, "Pleuropulmonary manifestations of hepatic amebiasis occurred in 30 patients . . ."; this is misleading. The 30 patients with hepatic amebiasis did not *all* have pleuropulmonary manifestations.

In the tables, the phrase "of 30 Patients With Pleuropulmonary Manifestations of Hepatic Amebiasis" was added to each title and this likewise implies that all 30 patients with hepatic amebiasis had pleuropulmonary manifestations.

The text of the manuscript, as well as the information in the tables, accurately shows the percentages of the patients with hepatic amebiasis who had pleuropulmonary manifestations.

I am sorry that I did not appreciate the effect these editorial changes would have on the text when I reviewed the galley proofs. I apologize for any confusion this may have caused.

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## More on Mohs'

To THE EDITOR: I wish to respond to Dr Safrin's letter,<sup>1</sup> responding to a review of Mohs' surgery by Dr Darmstadt and myself.<sup>2</sup> Dr Safrin states that Mohs' surgery is rarely indicated, inefficient, and costly, that the technique does not allow proper assessment of surgical margins, and that Mohs' surgeons are not qualified to interpret Mohs' surgery

frozen sections. These assertions are refuted by a large body of medical literature and by pathologists and dermatopathologists with extensive experience with Mohs' surgery.<sup>3</sup> The procedure has attained such wide acceptance that nearly every medical school in the country has a Mohs' surgeon on staff.

Mohs' surgery is frequently the treatment of choice for recurrent, incompletely excised, infiltrating, and ill-defined basal and squamous cell carcinomas.<sup>4-6</sup> It is recommended for treating skin cancers in locations prone to recurrence and in cosmetically important anatomic areas where tissue sparing is essential.<sup>7,8</sup> It is also very effective for treating many other common cutaneous cancers.<sup>2,7</sup> The medical literature solidly demonstrates that Mohs' surgery has the highest cure rate of any therapeutic modality for the treatment of basal cell and squamous cell carcinomas.<sup>4-6</sup> Several large studies of five-year determinant cases report cure rates for basal cell carcinoma using the Mohs' technique exceeding 98%.<sup>5,6</sup>

A major advantage of Mohs' surgery is its efficiency and cost effectiveness. In experienced hands, tissue processing routinely takes only minutes to complete,<sup>9</sup> and this work is done by a specially trained technician. During this time, the patient is in a waiting room, not occupying an operating room. The Mohs' surgeon's time is required only for the surgical procedure and for interpreting the frozen sections. Some pathologists may view the technique as inefficient, time-consuming, or expensive because they do not delegate the processing of the tissue to a trained technician. Compared to the cost of conventional frozen section procedures requiring a surgeon, an operating room and its nursing staff, and a pathologist, Mohs' surgery is not labor-intensive or expensive. Also, when less effective treatments are used, recurrences are more common. These must then be re-treated, resulting in further patient morbidity and increased medical costs.

Dr Safrin states that it is impossible to obtain a truly flat, complete Mohs' frozen section, cut parallel to the cryostat's cutting surface, and one must therefore cut excessively into the tissue block. He also suggests that the technique distorts the relationship between adnexal structures and the epidermis and the relationship of tumor foci to the surgical margin. The techniques for preparing Mohs' frozen sections are not routinely known to many pathologists or even licensed histologic technicians. Flat, properly oriented frozen sections from the outermost 100 microns of the surgical margin are the norm in Mohs' surgery and are easily obtained with the proper training and equipment. Moreover, serial sections cut into the tissue block at regular intervals allow for assessment of the relationship of tumor islands and adnexal structures to the surgical margin and the epidermis.

Finally, Dr Safrin questions the competence of Mohs' surgeons to interpret frozen sections accurately. Mohs' surgeons are trained during a one-year postresidency fellowship, where they read thousands of frozen sections from hundreds of Mohs' cases. There are currently 34 such programs accredited by the American College of Mohs' Micrographic Surgery and Cutaneous Oncology. Since nearly all are dermatologists, they also receive three years of formal dermatopathology training during their residency. A recent comprehensive study has shown that Mohs' surgeons are as accurate as general pathologists in interpreting Mohs' frozen sections.<sup>10</sup> Because of the number of frozen sections they review, Mohs' surgeons have far greater experience interpreting horizontally oriented frozen sections of skin

and soft tissue than do most general pathologists or dermatopathologists.

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