
Biopsy! Biopsy! Biopsy!

In Melbourne, we have a generation of recently-retired plastic surgeons who, both collectively and individually, have brought global recognition to Australian plastic surgery excellence and produced a cohort of researchers and clinical contributors who populate the plastic surgical landscape today.

Among this group of retired plastic surgeons—which includes Taylor and Corlett, Morrison, Behan, the late O'Brien and the recently departed Don Marshall—there is one name that is less-often quoted in international literature. Nevertheless, this surgeon's contribution to teaching not only plastic surgery trainees but medical students and general medical and nursing staff, has been no less valuable.

During his working life, Edward John 'EJ' Anstee was a modest, generous and gifted clinical teacher and surgeon, moral compass, mentor, passionate patient advocate and patient voice of reason. He formed a type of social glue between the various, then parochial, camps of Melbourne plastic surgeons. Every year, his annual 'bonfire party' for the surgeons and staff at the Victorian plastic surgery unit—held at his 800 acre farm north of Melbourne—bridged any divides that might have existed between units, professional groups or colleagues. This was really the only event that saw plastic surgery, the family, and all its extended relatives, come together as one. Among Anstee's teachings over the years, several particularly valuable lessons stand out and have informed this author's practice every day of his working life.

Firstly, there was the manner in which Anstee looked after his patients and his staff. During each operating list we would break for tea as a group and he would ask each and every staff member in his

theatre (including the lowly registrar!) about what was happening in their life. In addition, following every single case that I was ever involved with as Anstee's registrar, I saw him personally prepare a toasted sandwich and hand-deliver it with a cup of tea to the grateful patient to whom he would then explain the outcomes of the surgery. Such acts of kindness have not been forgotten—not by the patients themselves nor the staff who witnessed them—and we would all do well to remember to emulate them in the high-pressured bustle of the modern surgical environment.

Secondly, his concept of always seeking to innovate and think laterally. It is a little known fact that EJ supported the introduction of osseointegration into Australia (with Steven Gray) and the adaptation of that technique for use in the hand.

Finally, there was his timeless teaching exclamation 'Biopsy! Biopsy! Biopsy!' It is probably this simple eloquent message that has stayed with me the most throughout my clinical practice and is the most important. As plastic surgeons we are often referred patients for a biopsy. The mind-set behind this referral may be a little frustrating to others due to the extra logistical task of arranging an additional clinical visit then obtaining the resulting histopathological diagnosis before a management plan may be formulated. This inconvenience, however, is surmountable and at least the concept of obtaining a biopsy to ascertain the nature of a suspect lesion has been considered.

A surprisingly common and concerning phenomenon, in contrast, is the apparent reluctance of some referring practitioners to perform a biopsy and/or their lack of recognition that a biopsy is even required in the first place.

All too often, plastic surgeons encounter patients in both the public and private sectors who have undergone multiple cycles of various, failed, non-surgical treatment without any actual thought to having a simple biopsy performed to characterise the underlying pathology. The treatment modalities used may include topical liquid nitrogen or creams, ‘scraping’ or radiotherapy. These patients—in whom key risk factors such as immunosuppressant or transplant history, sun exposure, past history and disease pathology are not infrequently encountered—are particularly vulnerable to precipitous disease progression and require an early diagnosis. Urgent treatment is critical to obtaining optimal oncological control. The patient may have been selected for less ‘invasive’ treatment because they were considered ‘too old’ or ‘medically frail’ or their case is ‘just not serious enough’ for surgery, however, with no histopathology to guide the clinical choices, the treating practitioner is actually flying blind.

Meanwhile, while these repeated attempts at empirical non-surgical treatment fail to definitively eradicate the lesion for which the patient originally attended, it has evolved from being easily-treatable into a far more difficult problem. The implication of this disease progression may be that, by the time that the patient is finally offered a simple biopsy, the lesion has progressed to a more advanced stage, anatomically complex lesion that may threaten vital structures—all on a background of a by-now even more frail patient. Therefore, due to the more extensive extirpation surgery that is required, instead of creating a defect that may previously have been treated using simple reconstructive options (such as direct closure, local flaps or skin grafts) the resulting defect may now require a more complex reconstruction.

In short, by neglecting this fundamental clinical tool—the biopsy (without mention of which any plastic surgery fellowship candidate would instantly fail their exam)—the clinician has unnecessarily propelled the patient upward along the so-called ‘reconstructive ladder’ of complex reconstructive options. Often the patient may be advanced to the very top rung of the ladder—the

free flap—in a patient cohort that can least afford it. Furthermore, empirical treatment of a suspected skin malignancy with an inappropriate treatment agent, in the absence of confirmed histopathology, for example treating a BCC with 5-FU, will lead to treatment failure.

In practice, these often elderly and already-weakened patients, time and time again, undergo reconstruction by free microvascular tissue transfer followed (if they are eligible) by adjuvant chemoradiotherapy, only to become more deconditioned, less independent and more physically unstable shadows of their former selves. Sadly, in our patient cohorts, such a clinical episode heralds the beginning of the end and is all so unnecessary.

Therefore, in all our work advocating for our patient’s wellbeing—in our teaching and interactions with trainees, GPs, paramedical and allied health staff—let us always remember the wise words, and practice the principles of, EJ Anstee; not least his defining principle of skin cancer management: ‘Biopsy! Biopsy! Biopsy!’ Hear hear!

Ramin Shayan MBBS PhD FRACS

*O’Brien Institute, St Vincent’s Institute for Medical Research
Fitzroy, Victoria, AUSTRALIA*

*Plastic, Hand and Faciomaxillary Surgery
The Alfred Hospital, Melbourne, Victoria, AUSTRALIA*

*Plastic and Reconstructive Surgery Department
Royal Melbourne Hospital, Parkville, Victoria, AUSTRALIA*

*Department of Plastic Surgery
St Vincent’s Hospital, Fitzroy, Victoria, AUSTRALIA*

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