Tips for Surgical Oncology

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Note: At my institution, the breast and melanoma service did not have inpatients, so there was no rounding on patients. Furthermore, there were no direct consults as all patients were referred via family physicians or dermatologists after finding evidence of malignancy on biopsy.

1. *General Tips:*
    a. Show up early and be interested. I typically showed up around 7:40 for OR days and 15 minutes early for clinic days.
    b. Be nice to everyone 😊
    c. Read around patients and take deep dives into their charts.

2. *Approach to patients with melanoma:*
    a. For new patients, try to answer the following questions on chart review: Who performed the initial biopsy and when was it done? Who referred this patient? Is this patient followed by Dermatology? From where was the sample taken? What was the Breslow depth of the biopsy (some attendings still also note Clark depth)? Was there evidence of ulceration, lymphovascular proliferation, satellitosis? Were there any positive lymph nodes if done? Was genetics done? Does the patient have a history of skin cancer?
    b. In the room, I would ask about risk factors: (observe for Fitzpatrick), tanning bed use, blistering sun burns, sunscreen use, smoking, occupation, previous personal or family history of skin cancers or any other cancers? I would then do a full cutaneous exam alongside lymph node exam. Make sure to look at the scalp, between the toes, and other places were skin lesions are missed.
    c. The vast majority of new patients will require wide local excision with sentinel lymph node biopsy if Breslow depth > 1 mm. Read up on staging, grading, prognosis if you are keen.
    d. In the OR, I would help with prepping the patient, retracting, cutting, and suturing the skin layer. My top tip for suturing is to practice running subcuticular stitches. After the surgery I would help clean up the patient.

3. *Approach to patients with breast cancer:*
    a. Most patients will present with DCIS or IDC by the time they reached our service. The standard education was that lumpectomy + radiation = mastectomy in terms of outcomes, recurrence was similar and did not result in any significant change in life expectancy, approximately 1 in 8 women (at age 85) will be diagnosed with breast cancer, approximately 1 in 5 women have positive margins with lumpectomy, if nodes are positive radiation is

mandatory, tamoxifen is usually paired with chemo, seromas are common post-surgery, etc.

b. For most new patients, I would have a pretty passive role, either confirming risk factors and HPI or simply shadowing. For post-op patients, I would see how their wounds were, if they had seromas (if large, in-office drainage would be offered if the patient desired; if drained 2-3 times, we recommended IR drainage), and then check up in terms of their general health. For follow-up patients, I asked about signs of mets to the brain (headache), bones (new pains in body), lungs (cough, shortness of breath), lymph nodes or breast (new lumps or bumps).

4. *Approach to studying:*
    a. Other than reading around patient cases, I would do Anki every day. I mainly used the AnKing v12 deck. I would also do 20-40 Step 2CK UWorld questions each day during the week and 60-100 questions each day during the weekend.
    b. I read all of Dr. Pestana's Surgery Notes and would read relevant sections in Surgical Recall.
    c. For anything I felt weak on, I would review that condition using Toronto Notes or AMBOSS.