Nonmelanoma facial skin malignancy includes those skin tumors of the head and neck, most commonly, basal cell carcinoma and squamous cell carcinoma. In the United States, these are the most prevalent forms of cancer. The incidence of nonmelanoma facial skin malignancy is rising dramatically. Physicians should be well versed on the appropriate methodology required to both evaluate and treat these patients.

The Maintenance of Certification module series is designed to help the clinician structure his or her study in specific areas appropriate to his or her clinical practice. This article is prepared to accompany practice-based assessment of preoperative assessment, anesthesia, surgical treatment plan, perioperative management, and outcomes. In this format, the clinician is invited to compare his or her methods of patient assessment and treatment, outcomes, and complications with authoritative, information-based references. This information base is then used for self-assessment and benchmarking in parts II and IV of the Maintenance of Certification process of the American Board of Plastic Surgery. This article is not intended to be an exhaustive treatise on the subject. Rather, it is designed to serve as a reference point for further in-depth study by review of the reference articles presented. (Plast. Reconstr. Surg. 121: 1, 2008.)

Disclosure: Neither of the authors has a financial interest in any of the products, devices, or drugs mentioned in this article.
rising dramatically. These tumors generate a total cost of $426 million per year. When treated in an office setting, costs average $492 per episode, whereas outpatient and inpatient costs average $1043 and $5537 per episode, respectively. The World Health Organization estimates that 12,000 global deaths per year are caused by these types of tumors.

**INITIAL PATIENT ENCOUNTER**

An individual may present to the plastic surgeon’s office with a concern about a specific facial lesion or with a prior biopsy performed by another physician. Clinically, these tumors range from erythematous, tan or off-white plaques, to smooth or ulcerative papules, nodules, subcutaneous nodules, or deep ulcerations. Their biological behavior is also quite variable, with some following a relatively benign course and others progressing to extreme mutilation, metastasis, and death.

Regardless of the situation, it is the operative surgeon’s responsibility to confirm the diagnosis of nonmelanoma facial skin malignancy before proceeding with formal excision. Obtaining material for diagnosis by means of shave excision or incisional biopsy is appropriate. If the lesion has pigmentation, the diagnosis of melanoma must be considered and, accordingly, this type of lesion should undergo full-thickness biopsy (the topic of melanoma is not covered in this article). In general, complete excision without a prior tissue diagnosis is inappropriate, unless an excisional biopsy is planned where the lesion is relatively suspicious and small in a region of straightforward reconstruction. For those patients who present with a prior biopsy, the actual report must be part of the operative surgeon’s records.

Consideration must be given to the skin malignancy histology. For basal cell carcinoma, aggressive tumors include ulcerative and morpheaform (sclerosing) variants. For squamous cell carcinoma, Marjolin ulcers are particularly aggressive. In addition, any recurrent tumors that previously underwent treatment should be managed with circumspection.

**EVALUATION**

Specific risk factors—both host and environmental—are associated with nonmelanoma facial skin malignancy and should be identified before intervention. Host factors are the genetically predetermined responses of an individual to the onslaught of environmental insults that lead to nonmelanoma facial skin malignancy. These host factors vary between individuals and cannot be altered. Host factors include such things as skin phenotype and photosensitivity, genetic syndromes, and other cutaneous lesions that predispose an individual. The Fitzpatrick classification is a helpful method of classifying overall risk of skin to ultraviolet light exposure. This helpful classification schema serves as a means of identifying those patients at higher risk for developing facial skin malignancy. The classification system runs from level I through VI, with I representing fair and easily burned skin and VI representing very dark skin that rarely burns. Genetic syndromes such as xeroderma pigmentosum, nevoid basal cell syndrome, albinism, epidermodysplasia verruciformis, and porokeratosis all decrease protection against sun exposure and consequently increase the risk of nonmelanoma facial skin malignancy. In addition, predisposing lesions such as nevus sebaceous of Jadassohn, actinic keratoses, and cutaneous horns can all undergo malignant degeneration over time and should therefore be addressed.

The immune system also plays a role in nonmelanoma facial skin malignancy, although the specifics have yet to be worked out. Individuals who chronically use immunosuppressive agents have an associated increased risk of developing aggressive cutaneous neoplasms, especially basal cell carcinoma and squamous cell carcinoma. Furthermore, an altered immune response is noted in chronically sun-exposed skin. In fact, one reason the incidence of nonmelanoma facial skin malignancy is increasing is thought to be because as the average population age increases, so does the cumulative effects of prolonged sun exposure, which in the face of decreased ability to repair DNA damage and muster immunologic response, means a greater likelihood of malignant transformation.

Certain environmental factors are associated with nonmelanoma facial skin malignancy. If there is a history of exposure to these outside elements, it should be documented. Such environmental factors include ultraviolet radiation, ionizing radiation, and certain chemicals including polycyclic aromatic hydrocarbons and heavy metals.

Because exposure to ultraviolet radiation in susceptible individuals is a major cause of nonmelanoma facial skin malignancy, prevention is possible through avoidance. A segment of the initial patient encounter should address preventative measures. These include the daily use of appropriate sunscreens and specific protective clothing.
Educational programs can indeed reduce ultraviolet radiation exposure.\(^4\)

Once a diagnosis of nonmelanoma facial skin malignancy is established, accurate preoperative health assessment is important to identify and correct any barriers to healing. Comorbidities such as malnutrition, heavy steroid use, diabetes, or poor vascular perfusion secondary to cigarette smoking can indeed alter wound healing following excision and reconstruction.\(^17\) A history of keloid formation should be elicited preoperatively so that proper precautions can be instituted.

Identifying a history of previous cutaneous carcinomas is also important, as the estimated risk of developing one or more new primary basal cell carcinomas or squamous cell carcinomas of the skin is 35 percent at 3 years and 50 percent at 5 years.\(^18,19\) In fact, some authors note an increased risk of melanoma in patients with a history of basal cell carcinoma or squamous cell carcinoma.\(^20\) Therefore, a thorough cutaneous examination is critical to search for other lesions. If the surgeon defers this, collaboration with a dermatology colleague is suggested because synchronous lesions are very common.

Documentation of the specific anatomical location, size in millimeters, and appearance of the cutaneous neoplasm is helpful, as it may be required for later staging. In addition, it will help the surgeon locate the lesion if a significant amount of time elapses from the initial biopsy and the final excision. Appearance includes such characteristics as color, margins, symmetry, diameter, and the presence of ulceration. The ABCD (asymmetry, border, color, and diameter) mnemonic used in melanoma is helpful here too.\(^21\) Many surgeons find photographic documentation of lesions an accurate and speedy means of mapping lesions.

Although metastatic spread of basal cell carcinoma is indeed rare (one in 1000 to one in 35,000), it is not impossible. Accordingly, palpation of the regional lymph nodes is indeed a mandatory part of the complete workup.\(^22\) Metastatic spread of squamous cell carcinoma, especially of the scalp, ears, and nostrils, is a real phenomenon (0.5 to 16 percent) but still relatively uncommon.\(^23\) Because there is in fact such low metastatic potential for nonmelanoma facial skin malignancy, there are no indications for routine sentinel lymph node biopsy.

Identification of palpable lymphadenopathy during examination necessitates further workup. Radiologic scanning, including a computed tomographic scan with contrast or a magnetic resonance imaging scan, can easily identify tumor burden within lymph nodes. Another option is fine-needle aspiration, which can be performed easily in the office setting. For those concerned about fine-needle aspiration in the neck, this procedure can be performed under ultrasound guidance by an interventional radiologist. Whichever method is selected, there is very little reason to perform open biopsy of the neck, as these other modalities should provide appropriate confirmation of metastatic spread during the preoperative evaluation. If regional lymphatic spread is indeed confirmed, simultaneous neck dissection is undertaken. Consideration of superficial parotidectomy with excision of its associated lymph nodes is important if these structures lie within the involved lymphatic basin. After neck dissection, if pathologic review confirms metastatic spread, consideration of postoperative radiation therapy is appropriate. The irradiated field must include the subdermal plexus between the primary tumor and the regional lymph nodes as well. When basal cell carcinoma or squamous cell carcinoma invades bone, appropriate staging mandates resection with postoperative radiation therapy. Exceptions include ear or nasal cartilage, where complete resection to negative margins is indeed possible.

Documentation of regional nerve function is also important. If appropriate, evaluation of facial nerve function may be helpful in predicting regional invasion. The same is true for sensory branches of the trigeminal nerve.

**MANAGEMENT OF NONMELANOMA FACIAL SKIN MALIGNANCY**

After performing the evaluation, consideration must be given to the management of the disease. There are several recognized means of treating nonmelanoma facial skin malignancies.

**Mohs’ Technique**

Mohs’ micrographic surgery,\(^24,25\) as modified by Tromovitch and Stegman,\(^26\) involves sharp excision of all visible tumor in saucer-like layers while simultaneously mapping the exact size and shape of the lesion. The original technique was created by Frederic Mohs in 1938 as a means of removing skin cancer while preserving normal tissue. Originally, the technique required application of 20% zinc chloride fixative paste directly onto the patient’s skin for fixation of the tissue. This fixative sat for 12 to 24 hours. The involved skin was then removed surgically by means of serial excision with microscopic control of tissue margins. This removal was performed in horizontal layers and color-coded with dyes to precisely orient specimens to a map of the patient. The technique was somewhat
painful and could take several days to perform but precisely removed only diseased tissue. Subsequent modifications included a fresh tissue technique whereby local anesthesia could be used before excision of the horizontal frozen sections. These sections were similarly taken from the undersurface of the excised tissue and examined microscopically but could be immediately fixed after removal from the patient. As with the original technique, when tumor is identified, it is localized on a map and the specific area is marked for further resection. This process is repeated until all tumor is removed.\textsuperscript{27} The excision of tumor and microscopic review are performed by the same individual. Cure rates for primary basal cell carcinoma treated by Mohs’ micrographic surgery have been reported as high as 99 percent, whereas cure rates for squamous cell carcinoma are slightly lower at 95 percent.\textsuperscript{4,27} Most authors agree that margins for squamous cell carcinoma must be slightly greater than those for basal cell carcinoma.\textsuperscript{4}

The stated advantage of Mohs’ micrographic surgery for excision of nonmelanoma facial skin tumors is the potential for significant tissue conservation. However, there is definite controversy as to the possible overuse of Mohs’ surgery. In addition, some authors question the true rate of tissue conservation when this technique is used.\textsuperscript{28–31} Even among those who use the Mohs’ technique, there is active discussion about significant variability in tissue conservation.\textsuperscript{32} Specific indications indeed exist for the use of Mohs’ micrographic surgery in treating nonmelanoma facial skin malignancy. These include the following: tumors in sites with a relatively high rate of treatment failure; tumors with poorly delineated clinical borders or arising from scar tissue; morpheaform (sclerosing) basal cell carcinomas; tumors in critical locations such as the eyelid, where it is desirable to conserve as much uninvolved tissue as possible; and recurrent basal cell and squamous cell carcinomas (Figs. 1 through 3).

**Frozen Section Control**

Nevertheless, in many cases of nonmelanoma facial skin malignancy, conventional frozen sections can be just as effective in detecting residual tumor foci.\textsuperscript{4} Many plastic surgeons are presently excising cutaneous neoplasms and having frozen section margins immediately read by pathologists before performing the reconstruction. The primary author (R.I.S.Z.) uses this technique on nearly all nonmelanoma facial skin malignancies that are not of nodular histology. Pathologic review is immediately performed on all peripheral margins after excision of gross visual tumor is performed. These margins are 1 to 2 mm in width and

![Fig. 1. (Left) This patient presented with two large defects of the right medial eyebrow and right nasal tip following Mohs’ excision of basal cell carcinoma. He had been counseled preoperatively by the plastic surgeon regarding the various reconstructive options available to him before excision by the dermatologist. (Right) Follow-up view at 8 weeks after repair. The patient required a Limberg rhomboidal flap of the forehead and a sliding nasal dorsal flap of the nose.](image-url)
are appropriately oriented to the main specimen (mapped) so that if residual tumor is identified, specific regions can be reexcised. This technique requires the pathologist have a physical setup in close proximity so that rapid transport of the specimen is possible. In addition, the pathologist personally reviews the main surgical specimen and its associated defect in vivo within the operating suite before processing the margins so that there is total agreement with regard to mapping.33

Review of the senior author’s (R.I.S.Z.) nonmelanoma facial skin malignancies managed with this frozen section control technique was undertaken from January 1, 2002, through January 1, 2004. A surgical cohort was identified and followed until January 1, 2006, through retrospective chart review and telephone survey. This cohort numbered 67 patients. Those patients who died or were lost to follow-up were excluded from the cohort. There were no incidents of local recurrence during the follow-up period. This cure rate is comparable to that achieved with the Mohs’ technique. Unfortunately, few other formal controlled studies have been performed to date using the frozen section control method.34

When comparing malignancy recurrence rates of Mohs’ versus primary surgical excision, it is paramount to identify whether or not frozen section control was used. Many of the early studies from 1970 through 1980 using primary surgical excision did not use frozen section control whatsoever. These studies attempted to ascertain the appropriate diameter for excision in removing skin malignancies and had positive margins in as many as 7 percent of cases, especially in morpheaform (sclerosing) or superficial spreading variants of basal cell carcinoma. Generally speaking, these studies cite adequate margins are achieved with 3 to 5 mm of normal tissue.4 Unfortunately, these same studies that did not use frozen section control are cited by some physicians as demonstrating that surgical excision is not as efficacious as Mohs’ excision. This is indeed true when frozen section control is not used. What is needed in this debate is a comparison over time of the recurrence rate of nonmelanoma facial malignancy between the Mohs’ technique and the frozen section control technique with the Kaplan-Meier estimator.35

Other Techniques

The use of electrodesiccation and curettage or cryosurgery on the face should be reserved only for those small tumors where scarring is of minimal concern. These techniques, when applied aggressively, can leave an objectionable patchwork appearance to the face. In addition, these techniques are destructive in nature and do not allow pathologic review to ascertain whether or not complete excision of tumor has been achieved.

For those cancers that demonstrate superficial spread without deep invasion or those lesions with significant premalignant potential, consideration can be given to the use of topical agents. Pulse courses of 5-fluorouracil or imiquimod with close follow-up are indeed appropriate. Repeat biopsy af-
A 6-week course of treatment is a helpful means of documenting cure. Persistence of tumor indicates the need for further treatment with a different modality.

Although primary irradiation as a means of treatment produces few cosmetic defects initially, the results deteriorate over time. Fibrosis, ectropion, and ulceration are not uncommon sequelae. There is even a small risk of radiation osteitis and chondritis on treatment of certain areas. In short, radiation should be reserved for those patients who are poor surgical candidates, as it is a relatively safe and noninvasive modality but one that has potential long-term consequences.

Nevertheless, the use of radiotherapy as an adjuvant therapy is indeed reserved for those patients who demonstrate bone invasion at the primary site. In cases of cartilage invasion of the nose or ear, surgical excision should be able to clear this to negative margins and radiotherapy is not indicated, unless of course negative margins are not obtained. In addition, those patients with regional lymph node spread should undergo adjuvant radiotherapy as noted earlier after lymph node dissection. There is controversy regarding whether or not perineural invasion at the primary site, as demonstrated on histologic examination, represents a more aggressive form of cancer that would benefit from postoperative adjuvant radiotherapy. At the present time, no controlled studies support this.

If formal Mohs’ excision or surgical excision with frozen section control is performed, all tumor should be excised while the patient is in the operating suite. However, the occasion arises when total extirpation is not achieved. In addition, if only excision is performed, without any consideration to microscopic examination of margins, the situation may arise where there are still positive margins as demonstrated on permanent section. This is known as an incompletely excised nonmelanoma facial skin malignancy. Immediate reexcision is certainly the most prudent undertaking in this situation.

**CONSIDERATIONS FOR THE PLASTIC SURGEON WHEN TREATING PATIENTS UNDERGOING MOHS’ EXCISION**

The plastic surgeon may receive a consultation from a dermatologist who performed a Mohs’ excision of a nonmelanoma facial skin malignancy but was subsequently unable to repair the resulting defect. These patients must still be treated as outlined above. First and foremost, the plastic surgeon must establish whether or not all tumor was excised by the dermatologist. If not, this must be addressed. It is urged that the surgeon meet with the patient in an office setting, before surgical repair, to formally review the preoperative consent and discuss the appropriate reconstructive procedure. This is a good time to show the patient the actual defect so that expectations may be more easily managed. Many of these patients are anxious, as they have a large defect in their face for which they were not necessarily prepared. Documentation of formal consent is paramount. In addition, family members should be present who can simultaneously hear the discussion. Achieving this in a satisfactory manner is difficult if performed in the preoperative holding area of a surgical suite. Educating referring dermatologists regarding the
benefit of preoperative counseling with Mohs’ patients requiring plastic surgical reconstruction has its clear advantages.

As with all clean wounds, closure of the Mohs’ defect does not necessarily have to occur within a specified time frame if proper technique is followed. At all times, the Mohs’ wound should be curettaged to remove debris from the dermatologic procedure. Often there is foreign body, char, and necrosis within these wounds. Sometimes the Mohs’ defects are cut at an angle, with a bevel remaining in the dermal layer. Revising this at a 90-degree angle will allow for improved scarring. However, if the Mohs’ wound is greater than 12 to 24 hours old, debridement should be more aggressive, as the goal is to convert the wound into an acute defect, therefore allowing the surgeon to subsequently close it in a standard fashion. Standard perioperative antibiotic prophylaxis is recommended.

Some dermatologists advocate that Mohs’ defects should undergo granulation, which is also known as secondary intentional healing. Although this is reasonable for smaller defects, it can cause significant local skin contraction, including alar notching and ectropion. These scars tend to be more erythematous from prolonged inflammatory healing. In addition, the emotional cost to the patient should not be ignored, as the wound needs to be dressed daily as it heals over a prolonged period. If the plastic surgeon is consulted in this situation, the standard protocol applies as with all scar revision surgery.

**Coding Considerations**

The Current Procedural Terminology by the American Medical Association outlines the most recent definition of procedures. In 2003, changes were made in the method of measuring cutaneous lesions. These changes account for the clinical lesion diameter and the margins required for proper excision. Excised diameter is now defined as the greatest clinical diameter of the lesion plus the narrowest margin required on each side. This methodology accounts for repeat frozen sections as well. However, these measurements do not equal the diameter of the fusiform excision. Surgeons should be well versed with these concepts.

Nearly all Current Procedural Terminology codes for management of nonmelanoma facial skin malignancy may be found within the integumentary section of the current professional edition. Opportunities for common coding errors exist in the definition of complex closure versus adjacent tissue transfer. Surgeons occasionally and mistakenly code a fusiform excision with closure as an adjacent tissue transfer. These are in fact different procedures and surgeons must be familiar with the definitions.

Certain reconstructions may require cartilage grafting or canthopexy. These codes are located in the musculoskeletal section of the Current Procedural Terminology workbook.

**Anesthesia and Facility Considerations**

The physical status of the patient with regard to the American Society of Anesthesiologists classification mandates the level of monitoring required. In addition, the depth of anesthesia selected is also determined by such objective factors as the location of the malignancy, its overall size, and the subsequent complexity of the reconstruction. Subjective factors such as patient comfort and anxiety also play a role in determining the level of anesthesia. Local anesthesia, local anesthesia with sedation, and general anesthesia are all indeed appropriate after the above considerations.

Patient safety is the driving force behind the location selected in which to perform the procedure. American Society of Anesthesiologists guidelines should be followed at all times whether or not the procedure is performed in an accredited office or an outpatient or inpatient setting. If frozen section control is performed under sedation or general anesthesia, appropriate pathologic review must be available in a rapid manner to minimize anesthesia time. Direct communication between the pathologist and surgeon is helpful, especially if the pathologist can see the defect. Some outpatient facilities transport frozen specimen sections to a central processing area located off site. This adds unnecessary time to the procedure, makes communication between pathologist and surgeon difficult, and therefore should be avoided.

Only healthy patients should have nonmelanoma facial skin malignancies removed in a non-accredited office operating room under local anesthesia. Nevertheless, American Society of Anesthesiologists guidelines must be followed with respect to monitoring. Removal of nodular basal cell carcinoma with straightforward margins can be tackled in this type of setting. However, those nonmelanoma facial skin malignancies with indistinct margins (morpheaform basal cell carcinoma) should have pathologic margins assessed.
before surgical reconstruction and therefore may not be appropriate for an office setting unless frozen section margin control is available. Another option is to proceed with excision and perform delayed reconstruction following permanent pathologic review. For reasons of patient safety, deeper levels of anesthesia are absolutely inappropriate in nonaccredited surgical suites.

The duration of surgery must be monitored. The processing of margins (whether by Mohs’ technique or frozen section control) can indeed be time consuming. Many dermatologists using the Mohs’ technique will work on several patients simultaneously to maximize efficiency and have patients break sterile field to pass time. In contrast, using frozen section control technique can in fact be advantageous, as the operative surgeon is not physically reading the pathologic slides. This potentially generates two distinct advantages over the Mohs’ technique. First, selection bias is eliminated. This means that the pathologist has no vested interest in reading the margins as negative or positive. It is purely objective. Second, while the pathologist reads frozen sections, the operative surgeon can start planning or preparing the reconstruction. In addition, if the pathologist identifies a region of positive tumor and immediately communicates this fact, the surgeon can start excising further margins at the appropriately mapped site.

**CONCLUSIONS**

The incidence of nonmelanoma facial skin malignancy is clearly rising. This remains a personal burden to patients and a financial burden to the health care system. As insurance providers look to increase the efficiency of health care delivery, physicians must be positioned with evidence-based outcomes. At the present time, studies are needed comparing the long-term efficacy of the Mohs’ technique versus surgical excision with frozen section control for treatment of nonmelanoma facial skin malignancy. These studies must also look at the relative costs associated with the location in which these procedures are performed. Nevertheless, patient safety must remain the primary focus at all times when selecting the treatment modality and the facility location. As with many situations, ultimately each case may have a variety of appropriate treatment options with similar outcomes.

Ross I. S. Zbar, M.D.
200 Highland Avenue
Glen Ridge, N.J. 07028
risz@ix.netcom.com

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CPT Codes Commonly Used in Facial Skin Malignancy Surgery

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