Common Office Procedures

Bethany Panchal, MD
Associate Professor - Clinical
Associate Program Director
Department of Family Medicine
The Ohio State University Wexner Medical Center

Common Office Procedures

- Cryosurgery
- Shave biopsy
- Punch biopsy

Skin anatomy review

- Knowledge of skin anatomy critical to an effective procedure and understanding potential complications
- Epidermal thickness 0.05-1.5mm
- Dermal thickness 0.6-3mm

Image from National Cancer Institute

Cryosurgery

- Use of extremely low temperatures to produce local tissue destruction
- Liquid nitrogen most commonly used professionally
  - Produces much colder temps (-168C) than OTC products (i.e. dimethyl ether -24C)
**Cryosurgery - vehicles**

- Spray-tip canister
  - Direct contact not needed
- Cotton-tip applicator
  - Very precise
  - Small lesions near eyes
  - Children
- Metallic instrument
  - Frozen in LN
  - Clamp to skin tag

**Cryosurgery - mechanism**

- Heat is transferred away from cells to the LN - causing tissue necrosis
- The freezing causes cell destruction
  - Ice crystal formation
  - Cell membrane disruption
  - Vascular stasis
- Rapid cooling and slow thaw maximizes tissue destruction

**Cryosurgery - indications**

- Benign lesions - skin tags, seborrheic keratosis, warts, molluscum, keloids, solar lentigines
- Pre-malignant lesions - actinic keratosis
  - Take care to biopsy any suspicious lesion for SCC
- Malignant lesions – superficial basal cell carcinoma, squamous cell carcinoma in situ
  - Used for thin, well defined lesions when other treatments are contraindicated (rare)
  - Require longer freezing times to reach lower tissue temperature

**Cryosurgery - technique**

- Freeze fast, thaw slowly
  - Better intracellular ice formation is more damaging
- Repeat freeze-thaw cycles for maximal destruction
- General parameters for benign and pre-malignant lesions:
  - 1 to 2 cycles of 3-10 second freeze with 2mm lateral spread

<table>
<thead>
<tr>
<th>Cell Type</th>
<th>Temperature range for destruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanocytes</td>
<td>-4 to -7°C</td>
</tr>
<tr>
<td>Benign lesions (Keratinocytes)</td>
<td>-25 to -50°C</td>
</tr>
<tr>
<td>Malignant</td>
<td>At least -50°C</td>
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Cryosurgery video

Cryosurgery-follow up

- Expected side effects: Pain, edema, erythema, blister and crust formation

- Complications
  - Common: hypopigmentation (mild degree of freezing (-5°C) to irreversibly damage melanocytes)
  - Uncommon: scarring, nail dystrophy, alopecia

Cryosurgery

- Relative contraindications
  - Cold sensitivity (i.e. cold urticaria)
  - Ill-defined lesion, location (eyelid), tanned or dark skin

- Post-procedure care
  - Daily cleansing with soap and water
  - Petrolatum ointment
  - Sun protection
  - Healing expected within 1-3 weeks

Common Office Procedures

Kristen Rundell, MD, FAAFP
Associate Professor Clinical
Vice Chair For Education
Department of Family Medicine
The Ohio State University Wexner Medical Center
### Skin Biopsies

- Need to get informed consent
- Risks: Pain, bleeding, infection, scarring and the potential need for additional procedures
- Benefits: Diagnosis and potentially curative treatment

### Shave biopsy

- Most common skin biopsy technique
- Diagnostic role - obtain specimen for histologic exam
- Therapeutic role - remove an inflamed or symptomatic skin lesion
  - If the intent is complete lesion removal then the term “shave excision” or “shave removal” is used

### Shave biopsy

- Best for epidermal and superficial dermal processes
- Biopsy of suspected basal cell carcinoma or squamous cell carcinoma
- Removal of skin tags and other benign exophytic neoplasms

![Image from National Cancer Institute](image-url)

- Local anesthesia used to produce a wheal under the lesion
- Use a 15 blade or single-edged razor blade held semi-curved
- Move through skin in a sawing motion horizontally
  - Entering epidermis to depth of superficial dermis
- Goal is a shallow, saucer-shaped defect with a single intact specimen
- Submit specimen in 10% formalin or Michel’s solution for immunofluorescence
**Shave biopsy video**

- Deeper sampling than shave biopsy
- Diagnostic role - obtain specimen for histologic exam
  - Useful for rashes, dermal or subcutaneous nodules, melanocytic neoplasms
  - Therapeutic role - removal of small dermal neoplasms
  - "benign excision" or "punch removal" are best terms
  - Useful for cysts, inflamed dermal nevi

**Punch biopsy**

- Common punch tools vary from 2mm – 10mm
  - 4mm most common
- Oval-shaped defect is optimal
  - Created by spreading skin perpendicular to relaxed skin tension lines during biopsy
- Push and rotate punch tool to subcutaneous tissue (hub of the punch tool)
- Forceps and scissors used to extricate the specimen

**Punch biopsy closure**

- Sutures generally provide best closure
  - Nylon or polypropylene monofilament - require removal
    - 3-5 days for face (use 6-0)
    - 7-10 days for scalp and neck
    - 10-14 days for remainder of body
  - Fast-absorbing gut dissolves
  - Secondary intention (if less than 4 mm)
  - Wound closure strips in non tension areas
  - Absorbable sponge product is a good choice for areas that are difficult to suture.
Punch biopsy video

Skin biopsy side effects and wound care

- Side effects
  - Pain, bleeding, crusting
  - Secondary infection
  - Delayed healing, especially hands, feet, lower legs in elderly person
  - Scar formation
- Wound care
  - Daily cleansing with soap and water
  - White petrolatum ointment + bandage changed daily
  - Sun protection to prevent scarring

Skin biopsy – bleeding risk

- Caution if severe thrombocytopenia, bleeding disorder or anticoagulant use
  - Biopsy may still be performed but hemostasis may be delayed
  - Lower legs, hands, feet, digits, lips, and scalp prone to bleeding
  - Use anesthetic with epinephrine – except tips or ears, fingers, toes or genital area
  - May need to use aluminum chloride, pressure dressing or absorbable sponge

Skin biopsy relative contraindications

- History of keloid scarring
- Infection at biopsy site
- Anesthetic allergy
  - More common with esters than amides
  - Often due to a preservative rather than the anesthetic itself
- Options
  - Anesthetic of alternate class in a preservative-free formulation
  - 1% diphenhydramine solution
  - Normal saline
Conclusions

- Knowledge of skin anatomy is critical to successful performance of dermatologic procedures and understanding side effects
- When performing cryosurgery, tailor length of freeze and number of cycles to "thickness" of target lesion
  - Freeze fast and thaw slowly for best results
- Shave biopsy is best for epidermal and superficial dermal pathology
- Punch biopsy is best when assessment of dermal (or deeper) pathology is necessary

Office Procedures: Joint Injection Techniques

Larry Nolan II, DO, CAQSM
Clinical Assistant Professor, Department of Family Medicine & Sports Medicine
The Ohio State University Wexner Medical Center

Joint Injection Techniques

Objectives

- Injection, Aspiration
  - Indications for each
  - Relative and absolute contraindications
  - Outpatient setting (routine and urgent)
- Safety
  - Site identification and consent
  - Infection prevention
  - Prevent injury or tissue damage
  - Patient comfort
- Technique
  - Effective injection/aspiration
  - Key to success: anatomy

Joint Injection Techniques

- Indications
  - Diagnostic
    - Evaluation of synovial fluid
    - Local analgesia
  - Therapeutic
    - Improve pain/mobility
    - Adjuvant therapy
- Caution
  - Introduction of infection/worsen bleeding
  - Recurrence
Indications: Aspiration

- In setting of injury/trauma, historically:
  - Aspiration to obtain further diagnostic information
  - Hemarthrosis: ligament injury
  - Fat globules: bony injury
- Now essentially a historical use
  - Advances in imaging modalities
  - Avoid risk: injury, infection, or patient discomfort

Indications: Aspiration

- Diagnosis of infection or inflammatory arthritis, e.g.,
  - Gout, RA, Pseudogout, etc.
  - Send aspirate for microbiological or fluid studies
- Management of septic arthritis
  - Serial aspiration
  - Rarely used as part of management strategy
  - May also be used to monitor clinical response
  - Send follow up aspirate for evaluation

Indications: Therapeutic Injection

- Pain or inflammation of joint:
  - Osteoarthritis/ Degenerative Joint Disease
  - Rheumatoid Arthritis or other inflammatory arthropathy
- Tendonitis/Tenosynovitis/Bursitis:
  - Use Caution - may result in tendon injury
  - Inject bursa or tendon sheath
  - Rotator cuff tendinopathy/subacromial bursitis
  - Trigger finger, DeQuervain’s tenosynovitis
  - Greater Trochanter, pes anserinus, other

Indications: Therapeutic Injection

- Enthesopathies
  - Lateral epicondylitis (Tennis elbow)
  - Medial epicondylitis (Golfer’s elbow)
  - Achilles or Plantar fasciitis (caution)
Contraindications:

- Absolute:
  - Skin infection, contamination, or compromise at injection site
    - May be able to use alternate approach or location
  - Infected joint or bursa
    - Contraindication for Therapeutic injection
    - Indication for Diagnostic aspiration
  - Presence of Joint Prosthesis
    - Consult Ortho or refer patient back to treating surgeon
  - Patient preference/refusal

- Relative:
  - Anatomic difficulty
  - Severe scarring
  - Ankylosis
  - Deep structure (intra-articular hip)
  - Excessive soft tissue envelope
  - Consider image guidance
  - Coagulopathy
    - depending on strength of indication, may be managed proactively
  - No/Minimal relief from previous
  - Osteoporosis surrounding
  - Uncontrolled diabetes mellitus

Complications:

- Infection
- Reaction (local)
- Steroid flare
- Soft tissue atrophy
- Depigmentation
- Tendon rupture
- Systemic effects
- Direct needle injury

Safety: Site Identification and Consent

- Informed consent
  - Review procedure, risks and benefits with patient
  - Document! (may be verbal or written)
- Determine correct site - patient agreement
  - Follow your institutional protocol
  - Each site of procedure should be identified
- Alert patient
  - Verbal confirmation of appropriate site
- Non-participating patient–include representative
  - Mark site according to institutional protocol
Safety: Infection Prevention Skin Prep

• Decrease contamination/sterilize skin
• Do not place through non-intact skin!
  • Rash, cellulitis, psoriatic plaque, abrasion, etc.
  • May need alternate technique or delay procedure
• Skin Cleanse with antiseptic
  • Alcohol, Povidone-iodine and/or Chlorhexidine

Safety: Infection Prevention Skin Prep

• Using basic sterile technique to prep:
  • Always wear gloves
  • Scrub field in circular pattern
    • center and moving outward
  • Do not touch field with non-sterile object
  • May use sterile alcohol swab to wipe injection site
  • If hair removal needed - snip or use clipper, not razor
  • Allow alcohol to dry
    • Drying action hydrolyses bacteria to kill
  • Perform procedure immediately to avoid re-contamination

Safety: Patient comfort

• Try to make the experience as pleasant as possible
  • Avoid further discomfort or complications
  • Positioning, relaxation, watching, “Needle phobia”
• Use of Analgesics
  • Topical, local
• Accurate, confident injection technique
  • Know your anatomy and equipment
    • Needle and fluid “feel”
  • Difficult to reach target
  • Consider image guidance
  • Reassures patient

Safety: Infection Prevention

• Use “no-touch” technique to place needle
  • important to avoid contaminating “field” by touching prepped area with unsterile object, e.g. glove
  • use of sterile gloves or sterile drape is optional
    • may require prepping larger field, and help of assistant
    • may be helpful if you need to palpate area for accuracy
  • Cover with sterile dressing following injection
    • Compressive wrap optional
Injection Video:
Knee anatomy, Skin prep and Analgesia

Safety:
Avoid injury
- Direct mechanical injury,
  - bone, nerve, soft tissue, cartilage
- Vascular:
  - Intravascular injection, bleeding/bruising
- Skin compromise:
  - Fistula formation
- Important to know anatomy of the area
- Medication Safety
  - Avoid allergy, side effects

Safety:
Medication - Steroid
- Efficacy generally accepted but little evidence
- Systemic side effects
  - Short term:
    - hyperglycemia
      - Persists for variable period following injection
  - Long term:
    - AVN
    - impaired immunity
    - adrenal suppression
  - Relatively rare with common injection dosing and occasional use
- True Allergy uncommon
  - May include allergy to carrier or other component of formulation
  - Still reported - rarely
- Local effects
  - Increased risk of infection
    - Possible increased risk of future periprosthetic infection
  - skin depigmentation
  - tendon attrition/tears
  - Actual effect on joint unknown, difficult to pinpoint
Safety: Medication - Local anesthetics

- Lidocaine, ropivacaine, bupivacaine, etc.
- Allergy
- Toxicity
  - High intra-articular concentration linked to chondrotoxicity
  - CNS and Cardiovascular effects
    - Large dose
    - Inadvertent intravascular injection

Injection/Aspiration Technique

General comments:
- Sterile prep of area
- Collect needed materials ahead of time
- Consider aspiration of the area just prior to injection
  - MAY yield fluid, confirming needle tip in "space"
  - Not always successful:
    - Smaller space, Minimal effusion
    - Edematous inflammatory tissue may obstruct needle on aspiration.
  - Safety: confirm that needle is NOT intravascular.
  - No blood return
- Fluid flow
  - Free flow of fluid -> needle reached the target

Injection Setup

Injection/ Aspiration Technique Tips and Tricks-Needles

- Use same size needle for injecting/aspirating same fluid each time
  - consistent “feel” for the flow
- Smaller gauge may produce too much resistance to flow:
  - false feeling of not being in the space with injection attempt
  - may yield a false “dry tap” with aspiration attempt
- Larger gauge: flow may feel “too easy” even if not in joint.
- Needle length: Spinal needle for deep structures
  - Larger gauge due to flexibility and resistance to flow (18 or 20g)
**Specific Technique: Knee**

- Relevant anatomy
  - Joint capsule extends from just below joint line to above patella, including suprapatellar pouch
  - Fibular head is lateral side, below joint line
  - Extra articular
  - Prepatellar bursa DOES NOT communicate with joint normally, Suprapatellar Bursa DOES.

**Simulation of Knee Injection with Anatomic Model**

**Specific injection technique:**

- Approach: anterior medial (1)
  - Knee flexed, patient seated
  - Medial femoral condyle
  - Needle aims directly posterior
  - Touch but do not penetrate articular cartilage
- Approach: anterior lateral (2)
  - Knee flexed, patient seated
  - Lateral arthroscopic portal
  - Location corresponds to lateral joint line, just lateral to Patella tendon
  - Aim needle posteromedially to enter femoral notch
  - Fluid should flow freely, otherwise advance slightly and gently apply pressure again
    - Needle may be in prepatellar fat pad

- Approach: lateral suprapatellar
  - Knee extended, patient supine
  - Inject suprapatellar pouch from lateral side
  - Palpate IT band (Posterior) and Quad Tendon (Anterior)
  - Insert needle at level just proximal to superior pole of patella
  - Should feel resistance at capsule, then "Pop" through
  - Needle should be able to pivot proximal and distal under patella/quad tendon
**Injection of pre-injected Knee with Viscosupplementation**

**Specific technique:**
Greater Trochanteric Bursa Injection

- Approaches:
  - Posterolateral “hip” / upper thigh
  - Lateral decubitus with affected side up
  - Can be done with patient standing and leaning over a table
    - Spinal needle sometimes needed for length
    - if large soft tissue envelope

**Indications**

- Trochanteric “bursitis”
  - Maximally Painful area of posterolateral trochanter
    - may not correspond to physical fluid sac
  - Differentiate from Gluteus Medius tendon insertion
  - Inject point of maximal tenderness
    (NOT G. Medius!)
  - Avoid injection of tendon to avoid attritional tear

**Specific technique:**
Greater Trochanteric Hip Injection

- Indications
  - Trochanteric “bursitis”
    - Maximally Painful area of posterolateral trochanter
      - may not correspond to physical fluid sac
    - Differentiate from Gluteus Medius tendon insertion
    - Inject point of maximal tenderness
      (NOT G. Medius!)
    - Avoid injection of tendon to avoid attritional tear

**Specific technique:**
Greater Trochanteric Bursa Injection
Specific Technique: Shoulder Subacromial Injection

- Relevant anatomy
  - Subacromial bursa is separate from Glenohumeral joint if rotator cuff is intact
  - Lies between the Acromion and the rotator cuff tendons
- Positioning:
  - Seated upright or supine/beach chair
    - Seated position opens up subacromial space due to gravity on arm
  - Note: If there is full thickness Rotator Cuff tear, medication also reaches the Glenohumeral joint

Specific Technique: Shoulder Subacromial Injection

- Diagnostic and/or therapeutic
- Indications
  - Subdeltoid/subacromial bursitis
  - Rotator cuff impingement
  - Rotator cuff tendinopathy
  - Adhesive capsulitis

Specific Technique: Shoulder

- Multiple Shoulder injection targets
  - Subacromial Bursa
    - Most commonly performed
    - Topic of this instruction
  - Acromioclavicular Joint
    - Small joint superior/anterior to GH joint, lateral end of clavicle
    - May be difficult due to osteophytes
  - Glenohumeral Joint
    - (Intra-articular Shoulder)
    - Ultrasound guidance

Specific Technique: Shoulder Subacromial Injection

- Palpate the distal, lateral, and posterior edges of acromion
- As prior with aseptic technique
- Needle is inserted just inferior to posterolateral edge of acromion
  - Directed anteromedially
Acknowledgement

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References

• Sterile technique: https://onesource.osumc.edu/departments/PerioperativeServices/Documents/UHRossPolicies/Aseptic%20Technique%20UH.pdf