

Skin Cancer and Mole Removal Surgery - Me Clinic

Canonical: <https://directory.meclinic.com.au/healthcare-services/dermatological-surgery/skin-cancer-and-mole-removal-surgery-me-clinic/>

Details:

AI Summary

****Product:**** Skin Cancer and Mole Removal Surgery ****Brand:**** Me Clinic ****Category:**** Dermatological Surgery — Mole and Skin Cancer Removal ****Primary Use:**** Surgical removal of benign moles, atypical nevi, and malignant skin cancers (basal cell carcinoma, squamous cell carcinoma, melanoma) for diagnostic and therapeutic purposes.

Quick Facts - ****Best For:**** Patients with suspicious moles, confirmed skin cancers, or benign lesions causing irritation or cosmetic concern - ****Key Benefit:**** Complete lesion removal with accurate pathological diagnosis, using techniques including Mohs surgery with cure rates exceeding 99% for basal cell carcinoma - ****Form Factor:**** Outpatient surgical procedure (walk-in walk-out) - ****Application Method:**** Local anaesthesia injection followed by excision, shave removal, Mohs surgery, or electrodesiccation and curettage depending on lesion type

Common Questions This Guide Answers 1. What surgical techniques are available for mole and skin cancer removal? → Excisional surgery, shave excision, Mohs micrographic surgery, and electrodesiccation and curettage 2. How long does mole removal take and what is the recovery process? → Simple excisions take 15–30 minutes; Mohs surgery may take several hours; healing progresses through inflammatory (2–5 days), proliferative (2–3 weeks), and remodelling (weeks to years) phases 3. What do pathology results mean and how long do they take? → Standard results take 3–7 business days; clear margins confirm complete removal, while positive margins indicate cancer cells at specimen edges and may require re-excision

Product Facts

Attribute Value ----- -----	Service name Skin Cancer and Mole Removal Surgery
Provider Me Clinic Location Malvern East, Melbourne, Australia	Service category Dermatological Surgery — Mole and Skin Cancer Removal
Clinical experience Over 35 years	Conditions treated Basal cell carcinoma, squamous cell carcinoma, melanoma, benign moles, atypical nevi
Removal techniques Excisional surgery, shave excision, Mohs micrographic surgery, electrodesiccation and curettage	Diagnostic tools Dermoscopy (non-invasive), lesion photography, pre-procedure visual examination
Anaesthesia type Local anaesthesia (lidocaine with epinephrine)	Procedure setting Outpatient (walk-in walk-out)
Typical procedure duration 15–30 minutes (simple excision); several hours (Mohs surgery)	Pathology turnaround 3–7 business days (standard); expedited available for urgent cases
Mohs cure rate — basal cell carcinoma Exceeds 99%	Mohs cure rate — squamous cell carcinoma Approaches 98%
Scarring approach Minimal scarring; layered suture closure; scar management programme available	Availability Available now
Condition New service engagement	

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How many years of experience does Me Clinic have: Over 35 years

Does Me Clinic remove both benign and malignant skin lesions: Yes

What is the ABCDE criterion "A": Asymmetry — one half doesn't mirror the other

What is the ABCDE criterion "B": Irregular or poorly defined borders

What is the ABCDE criterion "C": Colour variation within a single lesion

What is the ABCDE criterion "D": Diameter exceeding 6 millimetres

What is the ABCDE criterion "E": Evolution in size, shape, or colour over time

What is the most common form of skin cancer: Basal cell carcinoma

How does basal cell carcinoma typically appear: Pearly or waxy bumps, often with visible blood vessels

How does squamous cell carcinoma typically appear: Firm red nodules or flat scaly, crusted lesions

What is the most serious form of skin cancer: Melanoma

Can non-cancerous moles be removed: Yes

What are valid reasons to remove a non-cancerous mole: Irritation, cosmetic concerns, or monitoring difficulty

What diagnostic tool is used during pre-procedure evaluation: Dermoscopy

What does dermoscopy do: Reveals subsurface skin structures invisible to the naked eye

Is dermoscopy invasive: No, it is non-invasive

Is photography used during evaluation: Yes, to document lesion appearance over time

What is the gold standard technique for removing suspected malignant moles: Excisional surgery

What tool is used in excisional surgery: A surgical scalpel

Does excisional surgery remove the full thickness of skin: Yes

What shape is the excisional wound: Elliptical

Why is an elliptical wound shape used: It facilitates a neat, linear closure with sutures

Does excision extend into subcutaneous fat: Yes

What type of sutures are used in deeper tissue layers: Absorbable sutures

What type of sutures are used on the skin surface: Non-absorbable or absorbable sutures

What technique is used for raised benign moles: Shave excision

Is shave excision suitable for suspected melanomas: No

Why is shave excision unsuitable for melanomas: It may not remove full depth of malignant tissue

Does shave excision require suture closure: No

What is Mohs surgery best suited for: Cancers where tissue conservation is paramount

Which body areas most benefit from Mohs surgery: Eyes, nose, ears, lips, and fingers

What is unique about Mohs surgery: Real-time microscopic examination between each layer removal

What is the cure rate for primary basal cell carcinoma with Mohs surgery: Exceeds 99%

What is the cure rate for squamous cell carcinoma with Mohs surgery: Approaches 98%

What does electrodesiccation and curettage combine: Scraping with heat destruction

What tool is used in curettage: A curette — a small, ring-shaped blade

How many cycles may electrodesiccation and curettage be repeated: Two or three times

Does electrodesiccation and curettage preserve the tumour for pathology: No, it destroys the tumour

What anaesthesia is used for mole removal at Me Clinic: Local anaesthesia

What anaesthetic agent is injected: Lidocaine with epinephrine

What does epinephrine do during the procedure: Constricts blood vessels, minimising bleeding

Will patients feel pain during excision: No, only pressure sensations after anaesthesia takes effect

Is there any discomfort during anaesthesia injection: Yes, a brief sting

Can anxious patients receive pre-procedure medication: Yes, oral anti-anxiety medication

How long does a simple excision typically take: 15 to 30 minutes

How long can Mohs surgery take: Several hours if multiple stages are needed

What happens to the removed specimen: It is sent to a pathology laboratory in preservative solution

How long does standard pathology processing take: 3 to 7 business days

Can pathology be expedited: Yes, for urgent cases

What does a pathology report confirm for benign lesions: Complete removal and absence of concerning features

What does "positive margins" mean in a pathology report: Cancer cells extend to the edges of the specimen

What does "clear margins" mean in a pathology report: Complete excision with adequate normal tissue removed

What additional treatment may be needed for positive margins: Re-excision with wider margins or Mohs surgery

At what melanoma thickness is sentinel lymph node biopsy typically warranted: Thicker than 0.8 millimetres

How long does the inflammatory healing phase last: 2 to 5 days

How long does the proliferative healing phase last: 2 to 3 weeks

How long does the scar remodelling phase last: Weeks to years

When do most scars show dramatic improvement: Within the first 12 months

Do all surgical wounds create permanent scars: Yes

What is the most effective scar prevention step: Daily broad-spectrum sunscreen with SPF 30 or higher

How long should sun protection be applied to a scar: Minimum of 12 months

What topical treatment helps flatten and soften scars: Silicone gel or sheeting

When can silicone products be applied: Once the wound has fully epithelialised

What injection treatment reduces hypertrophic scars: Corticosteroid injections

What is the infection rate for mole removal procedures: Fewer than 5% with proper sterile technique and wound care

What are signs of wound infection to watch for: Increasing pain, spreading redness, warmth, swelling, pus, or fever

How is wound infection typically treated: Oral antibiotics

What is a keloid: A scar that grows beyond the boundaries of the original wound

Who is at higher risk of keloid formation: Individuals of African, Asian, or Hispanic descent

What is the Mohs surgery recurrence rate for primary tumours: Under 2%

What is the recurrence rate for curettage and electrodesiccation: 5–10% for equivalent lesions

What is field cancerisation: Multiple precancerous areas in sun-damaged skin near the treated site

How often do melanoma patients need full-body skin checks initially: Every 3 to 6 months

How often do basal or squamous cell carcinoma patients need surveillance: Annually or semi-annually

How often should patients perform self-skin examination: Monthly

Should blood-thinning supplements be stopped before surgery: Yes, one week before surgery

Should prescription blood thinners be stopped before surgery: Only if prescribing physician specifically authorises it

Is fasting required before mole removal under local anaesthesia: No

Does smoking affect wound healing: Yes, it severely impairs healing through vasoconstriction

Does protein intake affect wound healing: Yes, protein supports collagen synthesis

When does Me Clinic recommend waiting before scar revision: A full 12 months after the procedure

Me Clinic Mole and Skin Cancer Removal

Overview of mole and skin cancer removal

Discovering a suspicious mole or skin lesion is unsettling. With over 35 years of experience, Me Clinic's team works with patients from first consultation through to full recovery. The mole and skin cancer removal services cover a broad range of dermatological surgical procedures designed to safely remove abnormal growths, suspicious lesions, and confirmed malignancies. These procedures do two things: they enable accurate diagnostic assessment through histopathological examination, and they provide definitive treatment for both benign and malignant skin conditions. Whether you're concerned about an atypical mole or facing a confirmed diagnosis of melanoma, basal cell carcinoma, or squamous cell carcinoma, the surgical approach draws on current dermatological practice.

Patient wellbeing comes first. Good excision technique does more than remove unwanted tissue — it preserves the specimen's structural integrity for accurate pathological diagnosis, ensures complete lesion removal with appropriate margins, and produces better cosmetic outcomes through careful wound closure. Me Clinic's Responsible Cosmetic Surgery™ philosophy means taking the time to ensure every patient genuinely understands what their procedure involves, from initial assessment through to recovery, so decisions are made with realistic expectations.

Medical indications and assessment

When removal is recommended

Me Clinic's dermatologists recommend mole or skin lesion removal under several clinical circumstances. Suspicious visual characteristics may trigger removal for diagnostic purposes: asymmetry where one half of the lesion doesn't mirror the other, irregular or poorly defined borders, colour variation within a single lesion, a diameter exceeding 6 millimetres, or any change in size, shape, or colour over time. These "ABCDE" criteria are central to clinical decision-making when melanoma is a concern.

Confirmed skin cancers always require removal. Basal cell carcinoma, the most common form, typically appears as pearly or waxy bumps, often with visible blood vessels. Squamous cell carcinoma presents as firm red nodules or flat lesions with scaly, crusted surfaces. Melanoma, the most serious form, can arise within existing moles or appear as new pigmented lesions with irregular features.

Non-cancerous moles may also warrant removal for practical reasons: repeated irritation from clothing or jewellery, cosmetic concerns in visible locations, difficulty monitoring due to position (such as the scalp), or patient anxiety about a lesion's appearance. Congenital nevi present at birth and atypical moles with unusual features may be prophylactically removed to eliminate future cancer risk, and the team will provide guidance to help patients make the right decision for their individual circumstances.

Pre-procedure evaluation

Before scheduling any removal, Me Clinic's dermatologists conduct a thorough visual examination, often using dermoscopy — a specialised magnification tool that reveals subsurface skin structures invisible to the naked eye. This non-invasive technique helps distinguish benign from malignant features, guiding whether immediate removal is necessary or whether monitoring is the more appropriate path.

Photography documents lesion appearance for comparison over time, giving both patient and clinician a clear baseline. For suspicious lesions, the dermatologist determines the most appropriate removal technique based on size, depth, location, and the level of concern for malignancy. High-risk lesions in cosmetically sensitive areas, such as the face, require different approaches from those used for lower-risk lesions on the trunk or extremities.

Surgical techniques and approaches

Excisional surgery

Excisional surgery is the standard approach for removing moles and skin cancers suspected of malignancy. Using a surgical scalpel, the dermatologist cuts through the full thickness of skin, removing the entire lesion along with a surrounding margin of normal-appearing tissue. The margin width depends on the lesion type — suspected melanomas require wider margins than basal cell carcinomas to ensure complete removal.

The excision extends into the subcutaneous fat layer beneath the dermis, creating an elliptical wound that allows a neat, linear closure with sutures. This technique provides the most complete specimen for pathological analysis, allowing laboratory examination of the entire lesion and confirmation that margins are clear of abnormal cells. Layered closure using absorbable sutures in deeper tissue and non-absorbable or absorbable sutures on the skin surface minimises scarring while giving the wound adequate strength during healing.

Shave removal

Shave excision removes raised lesions by cutting horizontally through the skin at the lesion's base using a surgical blade held parallel to the skin surface. This technique suits elevated benign moles,

seborrheic keratoses, and other superficial growths where deep invasion is not suspected. The wound base is left exposed rather than closed with sutures.

Shave removal works well for cosmetically sensitive locations and for patients with bleeding disorders, as bleeding is typically minimal and easily controlled with topical agents. It is not appropriate for suspected melanomas or deeply invasive cancers, as it may not remove the full depth of malignant tissue and can complicate accurate pathological staging.

Mohs micrographic surgery

Mohs surgery is the most precise technique available for removing skin cancers in locations where tissue conservation matters most — around the eyes, nose, ears, lips, and fingers. The surgeon removes a thin layer of visible tumour, examines it immediately under microscopy, then removes additional layers only where cancer cells remain at the margins.

This real-time pathological assessment continues until margins are completely clear, removing the minimum amount of healthy tissue while ensuring complete cancer elimination. Cure rates exceed 99% for primary basal cell carcinomas and approach 98% for squamous cell carcinomas, making Mohs surgery the treatment of choice for high-risk or recurrent cancers in critical locations.

Electrodesiccation and curettage

This two-step technique combines scraping (curettage) with heat destruction (electrodesiccation) to treat superficial skin cancers and precancerous lesions. The dermatologist uses a curette — a small, ring-shaped blade — to scrape away soft tumour tissue, then applies an electric needle to destroy remaining cancer cells and control bleeding. The cycle may be repeated two or three times to ensure thorough treatment.

While effective for low-risk basal cell and squamous cell carcinomas on the trunk and extremities, this technique destroys the tumour rather than preserving it for pathological examination. It's not suitable when precise depth assessment is required or when confirmation of complete removal is necessary for ongoing treatment planning.

The procedure experience

Anaesthesia and preparation

Nearly all mole and skin cancer removals at Me Clinic are performed under local anaesthesia in an outpatient setting. The dermatologist injects lidocaine with epinephrine around the lesion, numbing the area within minutes. Epinephrine constricts blood vessels, minimising bleeding during the procedure and extending the duration of anaesthesia. Patients remain fully conscious throughout, experiencing only pressure sensations once the anaesthesia has taken effect.

The injection itself causes a brief sting — for most patients, this is the only discomfort during the entire procedure. For those who feel anxious, oral anti-anxiety medication taken before arrival can help. The skin is cleansed with antiseptic solution and sterile draping isolates the surgical field.

Duration and immediate process

Simple excisions of small lesions typically take between 15 and 30 minutes from anaesthesia to final bandaging. Larger excisions, more complex closures, or Mohs surgery extend this timeframe — Mohs procedures can span several hours if multiple stages are needed to achieve clear margins.

During the excision, patients feel pulling and tugging sensations but no pain. Dermatologists explain each step throughout the procedure. Following removal, the specimen is placed into preservative solution for transport to the pathology laboratory. Suture placement requires precision — aligning wound edges properly, minimising tension that could widen scars, and achieving the best cosmetic result possible given the size of the defect.

Immediate post-procedure care

After the procedure, the dermatologist applies antibiotic ointment and covers the wound with a sterile dressing. Pressure is applied for several minutes to ensure complete cessation of bleeding. Patients leave with written instructions for home care: keeping the area clean and dry initially, applying fresh ointment and bandages daily, and knowing which signs might indicate a complication.

For excisions requiring suture removal, follow-up appointments are scheduled after 5 to 14 days depending on location — facial sutures are removed sooner than those on the back or legs, where wound tension is higher. Absorbable sutures dissolve naturally over several weeks, eliminating the need for a removal appointment.

Recovery and wound healing

The healing timeline

Wound healing unfolds through overlapping phases spanning weeks to months. The inflammatory phase begins immediately, with blood clotting and immune cell infiltration, and lasts 2 to 5 days. During this time, the wound may appear red and drain small amounts of clear or slightly bloody fluid — normal signs that healing has begun.

The proliferative phase follows, typically lasting 2 to 3 weeks. Fibroblasts produce collagen, new blood vessels form, and epithelial cells migrate across the wound surface. The scar may appear pink or red, raised, and firm during this period — expected, not alarming. Sutures provide structural support during early healing but contribute little after 1 to 2 weeks, which is why their removal doesn't compromise wound integrity once adequate healing has occurred.

The remodelling phase extends from weeks to years. Collagen reorganises along tension lines, scar tissue gradually flattens and fades, and the wound gains strength approaching — though never fully matching — intact skin. Most scars improve dramatically during the first 12 months, with subtle continued refinement beyond that.

Activity restrictions

Post-procedure activity limitations protect the healing wound from disruption and the tension that can widen scars. For head and neck procedures, restrictions are minimal — avoiding vigorous exercise that raises blood pressure for the first 48 hours, with routine activities resuming normally otherwise. Trunk and extremity excisions, particularly on the back, shoulders, or legs, require somewhat more stringent limitations.

Heavy lifting, straining, bending, or exercise that stretches the wound should be avoided for 2 to 4 weeks depending on location and size. High-tension areas like the upper back demand longer restriction periods to prevent dehiscence — wound separation before adequate healing strength has developed. Swimming and soaking must wait until sutures are removed and the dermatologist has confirmed adequate healing, as prolonged moisture softens tissue and increases infection risk.

Scar management

All surgical wounds create scars — permanent marks where skin architecture differs from the surrounding tissue. Scar quality depends on multiple factors. Genetic predisposition plays a role; some individuals form thick, raised scars called keloids or hypertrophic scars. Wound location matters, as areas of high motion or tension tend to scar more noticeably. Closure technique and post-operative care are areas where both the surgical team and the patient can make a real difference.

Consistent sun protection for a minimum of 12 months is one of the most effective steps. Ultraviolet radiation stimulates melanocytes in healing tissue, causing hyperpigmentation that makes scars more visible. Broad-spectrum sunscreen with SPF 30 or higher, applied daily to the scar, is simple and effective. Silicone gel or sheeting applied once the wound has fully epithelialised helps flatten and

soften scars through hydration. Massage of mature scars can break down collagen adhesions and improve pliability over time.

For more problematic scars, Me Clinic's dermatologists offer corticosteroid injections to reduce hypertrophic scars, laser therapy to address redness or surface irregularity, and surgical scar revision to reposition incisions along more favourable lines.

Pathology results and follow-up

Understanding laboratory reports

Tissue specimens go to pathology laboratories where technicians process, section, and stain them for microscopic examination by dermatopathologists. Standard processing takes 3 to 7 business days, though urgent cases can be expedited. The pathology report provides the definitive diagnosis, classifying the lesion as benign, premalignant, or malignant.

For benign lesions, the report confirms complete removal and the absence of concerning features. For cancers, the report provides critical information including histologic type, depth of invasion, margin status, and prognostic features. Positive margins — meaning cancer cells extend to the edges of the specimen — indicate incomplete removal and the need for additional treatment. Clear margins confirm successful excision with adequate surrounding normal tissue removed.

Additional treatment needs

When pathology reveals incompletely excised cancer, further intervention becomes necessary. Options include re-excision of the site with wider margins, Mohs surgery if not initially performed, radiation therapy for patients unable to tolerate additional surgery, or close monitoring in carefully selected cases where the risks of further intervention outweigh the benefits.

High-risk features in pathology reports — deep invasion, perineural involvement (where cancer tracks along nerves), or aggressive histologic subtypes — may prompt referral to oncology specialists for staging evaluation and treatment planning. Melanomas thicker than 0.8 millimetres typically warrant sentinel lymph node biopsy to determine whether cancer has spread beyond the primary site.

Surveillance protocols

Patients who have had skin cancer face an elevated risk of developing additional cancers. Surveillance schedules depend on cancer type and individual risk factors. Those with a history of melanoma typically need full-body skin examinations every 3 to 6 months for the first several years, then annually if no recurrence occurs. Patients with a history of basal cell or squamous cell carcinoma generally need annual or semi-annual checks.

Self-examination between dermatology visits is useful for early detection of new or changing lesions. Inspecting all skin surfaces monthly, using mirrors for difficult-to-see areas, and promptly reporting any concerning spots are practical habits worth building. Photography of existing moles creates a useful baseline for comparison, helping to identify subtle changes over time.

Risk considerations

Procedural risks

In keeping with the Responsible Cosmetic Surgery™ philosophy, Me Clinic is straightforward about the risks associated with any procedure. Mole and skin cancer removal is generally very safe, but every surgical intervention carries inherent risks. Bleeding during or after the procedure occasionally occurs, particularly in patients taking anticoagulant medications. Most bleeding responds to direct pressure, though significant hematoma formation may require drainage. Temporary discontinuation of blood-thinning supplements is often recommended when safely feasible, in coordination with prescribing physicians.

Infection develops in fewer than 5% of procedures when proper sterile technique and wound care are maintained. Signs to watch for include increasing pain, redness spreading beyond the immediate wound, warmth, swelling, pus drainage, or fever. Oral antibiotics typically resolve infections without lasting complications.

Nerve damage is a rare but serious risk, particularly when removing lesions near major nerves. Temporary numbness around wounds affects most patients to some degree, gradually improving over months as nerve fibres regenerate. Permanent sensory changes, or — very rarely — motor deficits, can occur with procedures in high-risk anatomic locations.

Scarring concerns

Dissatisfaction with cosmetic outcomes is the most common patient concern following removal procedures. All excisions create scars, though skilled technique minimises their appearance. Several factors beyond the surgeon's control also influence results: individual healing capacity, skin type, age, and wound location all play meaningful roles.

Patients with a history of keloid formation face particular challenges. Keloids — scars that grow beyond the boundaries of the original wound — occur more frequently in individuals of African, Asian, or Hispanic descent, and in high-tension areas such as the chest, shoulders, and upper back. Discussing this predisposition before proceeding allows the team to select the most appropriate technique and develop a tailored post-operative scar management plan.

Recurrence risk

Skin cancers can recur at treatment sites if initial removal was incomplete or if microscopic cancer cells extended beyond the excised tissue. Recurrence rates vary by cancer type and treatment method. Mohs surgery offers the lowest recurrence rates — under 2% for primary tumours — while curettage and electrodesiccation show higher rates of 5–10% for equivalent lesions.

Even with complete removal, the field cancerisation effect — where sun-damaged skin harbours multiple areas of precancerous change — means new cancers can develop in nearby locations over time. This doesn't indicate a failure of the original treatment; it reflects the patient's intrinsic cancer risk and accumulated ultraviolet damage. This is precisely why ongoing surveillance and sun protection matter.

Optimising outcomes

Choosing the right provider

Dermatologists receive specialised training in skin cancer recognition, removal techniques, and reconstructive closure methods, and board certification confirms completion of accredited residency programmes and comprehensive examinations. Me Clinic's practitioners bring over 35 years of collective experience to each case. For straightforward cases, general dermatologists provide excellent care. Complex cases benefit from specialists: Mohs surgeons for high-risk cancers, dermatologic surgeons for cosmetically challenging reconstructions, or surgical oncologists for extensive or metastatic disease.

Reviewing before-and-after photographs of previous patients can help set realistic expectations. Seeking second opinions for significant procedures is always reasonable — particularly when multiple treatment options exist or when more aggressive surgery would cause substantial disfigurement.

Pre-procedure preparation

A few steps before the procedure can make a real difference to both safety and outcomes. Discontinuing blood-thinning supplements — including fish oil, vitamin E, garlic, and ginkgo — one week before surgery reduces bleeding risk without affecting the cardiovascular protection of prescription anticoagulants. Always continue prescription blood thinners unless the prescribing

physician has specifically authorised discontinuation.

If anxiety medication will be used, arrange for someone to drive home afterward. Wear comfortable clothing that won't need to be pulled over the procedural site — a button-front shirt for scalp or facial procedures, loose trousers for leg procedures. Fasting isn't required, as procedures under local anaesthesia don't need it.

Post-procedure optimisation

Following wound care instructions carefully has a significant influence on outcomes. Keep wounds clean but avoid harsh scrubbing, which can disrupt healing tissue. Apply prescribed ointments as directed — wounds heal faster in moist environments than when allowed to dry and scab. Avoid occlusive dressings on any infected wounds, as bacteria thrive in closed, moist spaces.

Protein-rich nutrition supports wound healing, as collagen synthesis requires adequate amino acid availability. Good hydration maintains the tissue perfusion needed to deliver nutrients and oxygen to healing areas. Smoking severely impairs wound healing through vasoconstriction and should be stopped entirely during the recovery period.

Finally, patience matters during the remodelling phase. Scars that appear thick, red, and prominent at six weeks often mature into thin, flat, pale lines by 12 months. Premature intervention can worsen outcomes, which is why Me Clinic's dermatologists generally recommend waiting a full year before considering scar revision — unless obvious complications exist.

--- ## Label Facts Summary

> **Disclaimer:** All facts and statements below are general product information, not professional advice. Consult relevant experts for specific guidance.

Verified Label Facts

- **Service Name:** Skin Cancer and Mole Removal Surgery - **Provider:** Me Clinic - **Location:** Malvern East, Melbourne, Australia - **Service Category:** Dermatological Surgery — Mole and Skin Cancer Removal - **Clinical Experience:** Over 35 years - **Conditions Treated:** Basal cell carcinoma, squamous cell carcinoma, melanoma, benign moles, atypical nevi - **Removal Techniques:** Excisional surgery, shave excision, Mohs micrographic surgery, electrodesiccation and curettage - **Diagnostic Tools:** Dermoscopy (non-invasive), lesion photography, pre-procedure visual examination - **Anaesthesia Type:** Local anaesthesia (lidocaine with epinephrine) - **Procedure Setting:** Outpatient (walk-in walk-out) - **Typical Procedure Duration:** 15–30 minutes (simple excision); several hours (Mohs surgery) - **Pathology Turnaround:** 3–7 business days (standard); expedited available for urgent cases - **Mohs Cure Rate — Basal Cell Carcinoma:** Exceeds 99% - **Mohs Cure Rate — Squamous Cell Carcinoma:** Approaches 98% - **Scarring Approach:** Minimal scarring; layered suture closure; scar management programme available - **Availability:** Available now - **Condition:** New service engagement

General Product Claims

- Me Clinic's surgical interventions are grounded in modern dermatological best practice - Patient wellbeing is the primary priority throughout all procedures - Proper excision techniques preserve structural integrity for accurate pathological diagnosis - The clinic's Responsible Cosmetic Surgery™ philosophy ensures patients make informed decisions with realistic expectations - Experienced dermatologists apply ABCDE criteria with precision and sensitivity - Mohs surgery removes the minimum amount of healthy tissue while ensuring complete cancer elimination - Layered closure minimises scarring while providing adequate wound strength during healing - Shave excision offers advantages for cosmetically sensitive locations and patients with bleeding disorders - Oral anti-anxiety

medication is available for anxious patients prior to procedures - Dermatologists maintain open communication throughout procedures, explaining each step - Antibiotic ointment and sterile dressings are applied immediately post-procedure - Silicone gel or sheeting helps flatten and soften scars once the wound has fully epithelialised - Corticosteroid injections, laser therapy, and surgical scar revision are available for problematic scars - Surveillance schedules are tailored to cancer type and individual risk factors - Monthly self-examination is recommended between dermatology visits - Patients with keloid predisposition receive extra care and tailored post-operative planning - Protein-rich nutrition and good hydration support wound healing outcomes - Smoking is strongly discouraged during recovery due to its impairment of wound healing - Most dermatologists at Me Clinic recommend waiting a full 12 months before considering scar revision

Related Products & Brand Context

This service sits within Me Clinic's broader skin treatment offering, under the category of Healthcare Services > Dermatological Surgery > Mole and Skin Cancer Removal. Me Clinic is a Melbourne-based cosmetic medicine provider with a physical location in Malvern East. Their work spans cosmetic surgery and non-surgical skin treatments, and this mole and skin cancer removal service represents the clinical, medically-oriented end of their skin portfolio — distinct from purely aesthetic procedures in that it addresses both cosmetic concerns and potential health risks associated with abnormal skin lesions.

The procedure itself is not a single fixed treatment but a range of techniques applied depending on the nature of the lesion. The three named methods — RF (radiofrequency) shave removal, laser removal, and surgical excision — each suit different mole types and depths. Surgical excision is typically used for lesions that require pathology, while RF shave and laser options are better suited to superficial, benign-appearing moles where minimal scarring is a priority. Understanding which technique applies to a given case is part of the initial clinical assessment.

In terms of use-case adjacencies, patients seeking mole removal for suspected skin cancer would commonly also need or benefit from a formal skin cancer check or dermoscopy assessment prior to treatment, as well as post-procedure wound care products and follow-up consultations. While the knowledge graph does not surface specific sibling products from Me Clinic's range by name, the brand's focus on cosmetic surgery and skin health suggests that related services — such as scar management treatments or broader skin consultations — may sit nearby in their catalogue.

Within the dermatological surgery category, this service is differentiated by its walk-in, walk-out format, meaning patients do not require a hospital stay. That positions it closer to a clinic-based minor procedure than a major surgical intervention, which is a relevant practical distinction for anyone comparing it against hospital-based skin cancer surgery options.