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The gluteal fold flap: A versatile option for perineal reconstruction following anorectal cancer resection

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Received 25 September 2012; accepted 14 February 2013

KEYWORDS

Gluteal fold flap;
Perineal reconstruction;
Abdominoperineal excision of the rectum;
Pelvic exenteration;
Rectal cancer;
Anal cancer

Summary *Introduction:* Gluteal fold flaps (GFFs) have been extensively reported for vulvo-vaginal reconstruction but there are no published series of their use for perineal reconstruction following anorectal cancer excision. In this context, abdominal myocutaneous flaps remain the method of choice but may be unavailable because of pre-existing abdominal scars, or need for a colostomy/urostomy. In addition, their abdominal wall morbidity makes them less acceptable, especially given the increasing use of laparoscopic techniques for the extirpative surgery. We document our experience using GFFs following radical anorectal cancer excision.

Methods: Data were collected from a single surgeon's consecutive cases performed over a five-year period (October 2007–May 2012). The indication, surgical procedure, complications and follow-up were recorded, as was the incidence of neoadjuvant/adjunct therapy.

Results: Ten gluteal fold fasciocutaneous flaps were performed in seven patients at the time of radical anorectal excision. The GFFs were performed alone (unilateral $n = 3$, bilateral $n = 3$) or in combination with a contralateral anterolateral thigh (ALT) myocutaneous flap ($n = 1$). The indications for anorectal excision were rectal adenocarcinoma ($n = 3$), anal squamous cell carcinoma ($n = 3$) and anal adenocarcinoma ($n = 1$).

All flaps survived completely although two patients required further surgery, one for evacuation of a late donor site haematoma and another to close a small, persistent wound dehiscence. The mean follow-up period was 24 months (range 2–57).

Conclusions: The GFF is a reliable, versatile and robust option for perineal reconstruction after extended anorectal excision, despite local irradiation, and should be considered for medium and selected large defects in this context.

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Introduction

Perineal defects following rectal and anal disease present a significant reconstructive challenge. They occur most commonly following abdominoperineal excision of the rectum (APER) or pelvic exenteration (PE) but may also arise after surgical management for congenital, traumatic or chronic inflammatory conditions.

Where a perineal defect remains following APER or PE, a wide variety of flaps have been described, predominantly using abdominal, pudendal, gluteal and thigh donor sites. Of these, abdominal myocutaneous flaps, such as the vertical rectus abdominis myocutaneous (VRAM) flap, are most commonly used and are widely reported in the literature.^{1–4}

However, recent technical advancements have enabled a reduction in abdominal morbidity from both the resection and the reconstruction. The advent of total muscle-preserving (abdominal) flap harvest techniques, and the increasing use of laparoscopic APER has drastically reduced the abdominal wall sequelae. As a consequence, the standard use of a pedicled VRAM flap following APER or PE has been called into question, since the associated morbidity at the donor site is deemed less acceptable.⁴ Surgeons are therefore required to consider different reconstructive strategies, using alternative donor sites.

The perineum itself receives a rich blood supply and represents a versatile donor for local perforator flaps. The gluteal fold flap (GFF), first described by Yii and Niranjani in

Table 1 Summary of patients.

Patient	Age	Sex	Pre-operative		Indication	Procedure	Post-operative	Complications/Outcomes	Post-op stay (days)
			RT	Chemo					
1	64	M	N	N	Recurrent rectal adenocarcinoma	APER and posterior pelvic exenteration with right gluteal fold flap	N	Debridement of perineal wound dehiscence and V-Y flap advancement (2 months post-operatively)	18
2	38	F	N	Y	Recurrent anal SCC	Wider perineal excision (previous salvage APER), coccygectomy with bilateral gluteal fold flaps	N	Further local recurrence requiring excision of flaps, anterior vagina, urethra and bladder and bilateral gracilis myocutaneous flaps	7
3	66	M	Y	Y	Recurrent anal SCC	Salvage APER with right gluteal fold flap	N	Nil	18
4	59	F	Y	Y	Anal SCC	Posterior pelvic exenteration with a left pedicled ALT flap and right gluteal fold flap	Y	Evacuation of haematoma at GFF donor site (16 days post-operatively) Infected ALT donor site seroma (1 month post-operatively) Post-operative DVT requiring anticoagulation	25
5	77	M	Y	Y	Anal adenocarcinoma	APER with right gluteal fold flap	N	Nil	12
6	46	F	Y	Y	Rectal adenocarcinoma	Extralevator APER with bilateral gluteal fold flaps	N	Nil	13
7	62	F	Y	Y	Rectal adenocarcinoma	APER and posterior vaginectomy with bilateral gluteal fold flaps	N	Nil	12

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