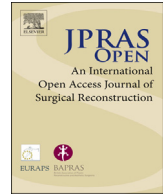




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Case report

Pinna fillet flap after advanced external ear tumor resection

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ABSTRACT

Reconstruction after excision of infiltrating basal cell carcinomas (BCCs) of the upper pole of the ear can be achieved with different techniques. The concept of spare-part surgery, which allows the surgeon to perform primary reconstruction of a defect without harvesting tissue from the adjacent areas, has been applied to the ear anatomy. We describe our experience with the use of a fillet flap from the residual external ear in two patients out of a series of six, undergoing reconstruction of ear defects after infiltrating BCC resection between January 2011 and December 2014. Reconstruction with the fillet of pinna flap was proven to be an easy surgical technique with good functional and cosmetic outcomes. Our technique, not previously reported, enhances the versatility of ear reconstruction.

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Introduction

Five main layers coexist in the auricular anatomical structure. The internal structure of the pinna is composed of a cartilaginous skeleton and a thin layer of perichondrium that surrounds and separates the cartilage from the external skin. The surgical treatment of skin cancer of the ear ranges from more

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conservative approaches^{1–3} to total or subtotal ear amputation when the tumor requires wider margins. At a meeting, we presented the use of a skin flap harvested from residual ear tissue, otherwise discarded, for the reconstruction of selected defects.⁴ The concept of filleting the pinna is based on “spare-part” reconstruction.⁵

We report two case descriptions, out of a series of six, of advanced skin cancer infiltrating more than two-thirds of the external ear, almost worth amputation. Lesions were excised and spared clear skin and perichondrium were used to partially or totally cover the residual wound.

Case 1

A 67-year-old man was referred to our clinic for a recurrent infiltrating carcinoma of the upper pole of the right ear (Figure 1). The patient was managed under general anesthesia; resection was performed with 1-cm skin margins, including the temporal fascia on the deep aspect, representing a subtotal amputation of the right ear. Reconstruction decisions were made based on the intra-operative histological examination result (IHER). IHER confirmed an infiltrative basal cell carcinoma (BCC) with clear margins. Reconstruction with a combination of flaps was performed. The clear helical rim skin and perichondrium of the middle third of the ear was dissected off its internal cartilaginous skeleton and used as a pinna fillet flap (PFF) for the reconstruction of the residual defect. The fillet flap was advanced cranially and rotated anteriorly to cover the postauricular wound. A superiorly based preauricular transposition flap was added to complete the reconstruction of the residual upper defect. A Penrose drain was applied (Figure 2). The duration of the surgery was 1 h and 25 m. The patient was discharged the following day after drainage removal. The flap remained viable with no partial flap loss. No dehiscence of the surgical wound was observed. The result remained stable over time; no revision surgery was required. Follow-up at 12 months showed no locoregional recurrence.



Fig. 1. Recurrent infiltrating carcinoma and preoperative planning.

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