



Contents lists available at ScienceDirect

Journal of Oral and Maxillofacial Surgery, Medicine, and Pathology

journal homepage: www.elsevier.com/locate/jomsmp



Case report

Superiorly based platysma myocutaneous flap for reconstruction of intra oral defect following fibrotomy in oral submucous fibrosis: Report of a case

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ARTICLE INFO

Article history:

Received 19 March 2017

Received in revised form 27 August 2017

Accepted 15 September 2017

Available online xxx

Keywords:

Oral submucous fibrosis

Platysma myocutaneous flap

ABSTRACT

Platysma myocutaneous flap is a versatile flap that has been used for head and neck reconstruction since more than three decades. It is a versatile flap based on an axial blood supply used for reconstruction of many intra oral defects like cheek mucosae, floor of the mouth etc. We report here a case of Oral submucous fibrosis Grade III treated with a superiorly based Platysma Myocutaneous flap for reconstruction of the post fibrotomy defect. The patient was followed up for a period of one year with excellent functional and aesthetic outcomes.

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1. Introduction

Oral submucous fibrosis (OSMF) is an insidious, chronic, disabling disease of obscure etiology that affects the entire oral cavity, sometimes the pharynx, and rarely the larynx. It is characterized by blanching and stiffness of the oral mucosa, which causes progressive limitation of mouth opening and intolerance to hot and spicy food. In the late stages, mouth opening is limited by severe scarring, which causes trismus [1]. This condition can be treated surgically or non-surgically, depending on the stage of presentation. Surgical management is the treatment of choice in cases with marked limitation of mouth opening, usually stages III and IV where the mouth opening is less than 25 mm [2].

Numerous surgical treatment modalities have evolved over time. These include simple release of fibrosis and Skin Grafting, use of a Bilateral Tongue flap, the Nasolabial flaps, the Island Palatal Mucoperiosteal flap, Bilateral radial artery forearm free flap, the Superficial temporal fascia flap with split skin graft and the use of BFP (Buccal Fat Pad) [2]. Though many surgical techniques have been recommended each of these techniques have its own advantages and limitations.

Platysma Myocutaneous Flap is a versatile flap that has been used for intraoral reconstruction since 1978 [3]. It has been used

for head and neck reconstruction in different superiorly based and posteriorly based designs. The advantages of this flap are the proximity to the surgical area, a large donor area, axial blood supply and the fact that the skin island pedicled by platysma muscle is easily harvested and transplanted to the defect. We present here a case of Oral submucous fibrosis grade III [4] treated with a superiorly based platysma myocutaneous flap.

2. Case report

A 36 yrs old patient reported with complaints of difficulty in mouth opening since 05 years and gave a progressive history of reduction in mouth opening and a habit of chewing gutkha since last 10 years. Clinical examination revealed severe blanching of the mucosa with vertical fibrous bands running over the buccal mucosae and faucial pillars with peri oral fibrosis around the commissure (Fig. 1). The soft palate was fibrosed with a bud shaped uvula. An interincisal mouth opening of 21 mm was recorded. He was motivated to give up the deleterious habit before surgical intervention.

2.1. Surgical technique

The patient was taken up under general anesthesia with nasotracheal intubation using a fiberoptic bronchoscope. Using a No. 15 Bard Parker blade an incision was made for release of fibrotic bands on each side of the buccal mucosa at the level of the occlusal

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Fig. 1. Preoperative intraoral picture showing fibrosis of the buccal mucosae and faucial pillars.



Fig. 2. Size of the skin paddle (3.5 cms x 2.5 cms) marked for harvesting flap.

plane avoiding the Stensen's duct. The incision line extended from the anterior faucial pillars to the corner of the mouth. The incised fibrotic bands were further disentangled manually until no restrictions were felt. The mouth was then forced open with a Heister mouth gag and an interincisal opening of approximately 35 mm was achieved. The coronoid processes were approached through the same incision and bilateral coronoidectomy was done. The maxillary and mandibular third molars were simultaneously extracted. An intraoperative interincisal mouth opening of 48 mm was achieved post coronoidectomy.

A superiorly based Platysma Myocutaneous muscle flap was raised as described by Baur [5] and used for reconstruction of the post fibrotomy defect. With the neck hyper extended the proposed skin paddle was outlined on the ipsilateral neck, below the inferior border of the mandible. The size of the skin paddle marked was approximately 3.5 x 2.5 cms approximately (Fig. 2). The superior incision was made first and a plane superficial to the platysma muscle was dissected carefully cephalic to the inferior border of the mandible. A skin incision was then made at the inferior line of the skin paddle, with additional exposure of the platysma muscle inferiorly. The platysma muscle was transected sharply at least 1 cm inferior to the edge of the skin paddle and a subplatysmal plane of dissection developed just below the inferior border of mandible.



Fig. 3. Mobilization of the harvested flap.



Fig. 4. Mobilized flap sutured to the post fibrotomy defect.

The skin paddle was sutured to the muscle to prevent shearing of the skin flap. Once the plane of dissection was fully developed, the Platysma Myocutaneous flap was transected vertically, anteriorly and posteriorly for full mobilization (Fig. 3). The flap was introduced into the oral defect by creating an approximately sized soft tissue tunnel. The harvested flap was sutured to the defect (Fig. 4), which was created by release of a fibrous band. The donor site was easily closed in layers to obtain an acceptable cosmetic result.

A soft splint was placed in the oral cavity postoperatively for 10 days to prevent dehiscence of the flap as a result of occlusal trauma. After a latent period of 10 days, physiotherapy was started

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