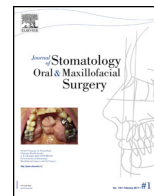




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Technical Note

A modified nasolabial flap for reconstruction of transfixing alar wing defects

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ABSTRACT

Reconstruction of an entire alar wing is a frequently encountered reconstructive challenge in onco-dermatologic surgery. The aim of this technical note was to describe a surgical technique total for reconstruction of the alar wing, with a modified nasolabial flap with an inferior pedicle associated with a cartilaginous graft. This rapid procedure seems to be a well alternative for elderly people and patients who do not want a forehead flap. The aesthetic and functional outcomes of the donor and recipient sites were satisfactory.

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1. Introduction

The alar wing is an anatomical unit that is very challenging to reconstruct because its anatomy, function, and specific shape are difficult to reproduce. The aim of this study was to describe an innovative surgical technique that allows for immediate reconstruction of the alar wing in three planes using a variation of the nasolabial flap with an inferior pedicle associated with a cartilaginous graft.

2. Procedure

An 80-year-old woman was admitted for an invasive basocellular carcinoma invading the perialar fold and tip of the nose (Figs. 1–6). After ablation of the tumor with an 8-mm margin, the defect measured 2.5 × 3.0 cm and extended through the totality of the nasal wing, a portion of the lateral part of the nasal dorsum, and the perialar region.

The reconstruction (Fig. 7) was carried out under general anesthesia. The drawing was identical to the one of the classical nasolabial advancement flaps in a V–Y shape with an inferior pedicle, with the internal margin in the nasolabial fold and the external margin in the cheek. The length was required to be three times greater than the initial defect to allow for optimal

advancement. The width of the distal third of the flap, which allows for coverage of the alar wing, was equal to the width of the initial defect. The particularity of this flap is the addition of an extension in the cutaneous upper lip at the superomedial side of the flap that is harvested as a thin layer including the intradermic vessels and turned inside of the nostril. This random flap allows for reconstruction of the free edge of the nostril and the mucosa.

The edges of the flap were incised and dissected far enough to allow advancement of the flap. The facial artery was identified at the bottom tip of the flap and dissected toward the proximal part of the flap at a 1- or 2-cm length to facilitate maximal mobility. The upper half of the flap, which was designed to contribute to the cutaneous reconstruction, was dissected until the deep layer and excess fat tissue were resected after harvesting. The labial extension was first superficially harvested taking care to the intradermic vascularization, and then turned inside the nostril. The flap was temporarily attached to the edges of the defect to assess the size, placement, and symmetry of the flap compared with the contralateral alar–facial sulcus. An aluminum template was used to determine the contours of the cartilaginous graft used to support the free edge of the nostril. The conchal cartilage graft was first harvested from the contralateral ear through a retroauricular approach, and then buried in the recipient site. A fixation stitch in the periosteum of the pyriform sinus was necessary to ensure the projection of the alar–facial sulcus. This stitch was locked down exteriorly to permit its ablation in case the vascularization of the distal part of the flap became compromised. The external sutures were resorbable 5–0 wires,

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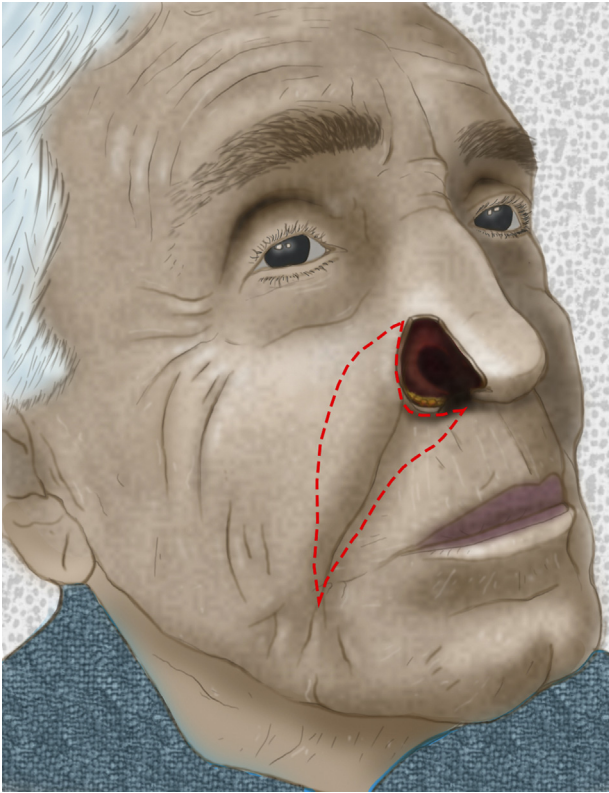


Fig. 1. Transfixing defect of the alar wing and drawing of the nasolabial flap with labial extension.

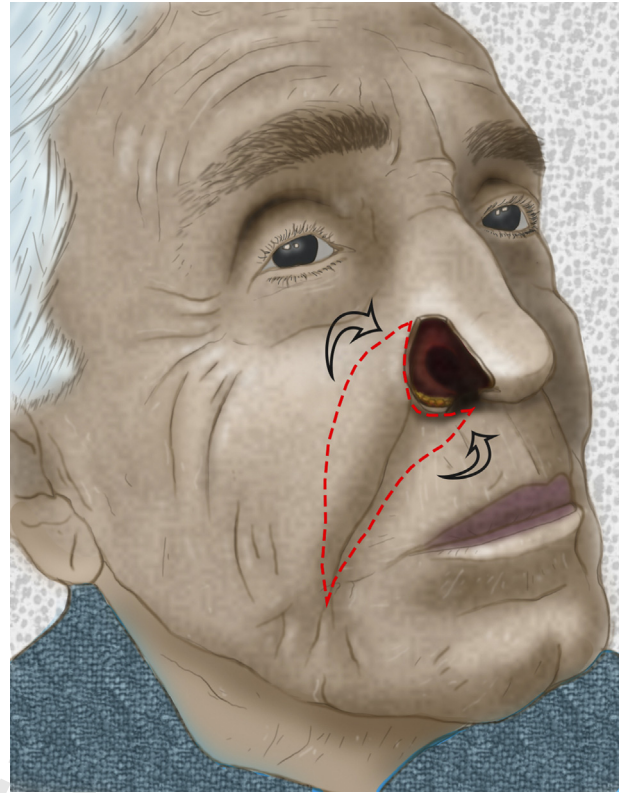


Fig. 3. Drawing of the nasolabial flap with labial extension and the potential transposition.

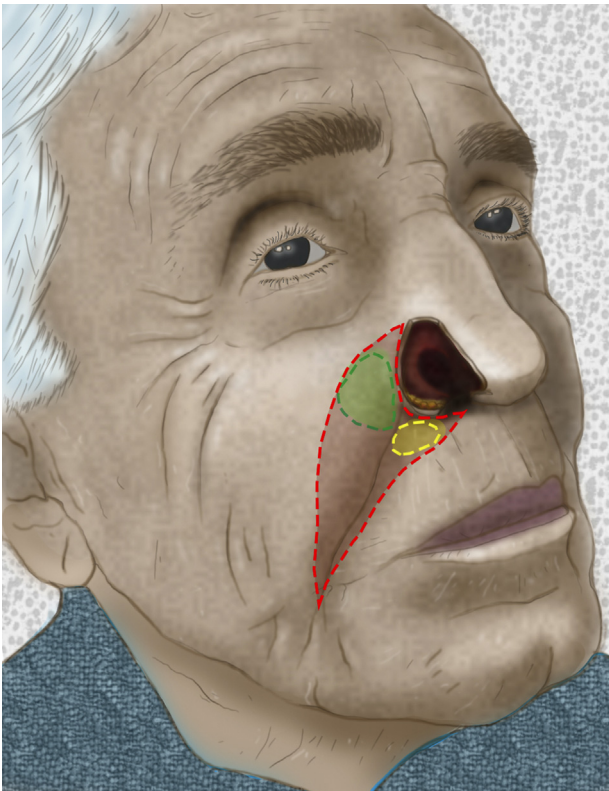


Fig. 2. The yellow area will be for the mucosal part. The green area will be for the external area of the wing.

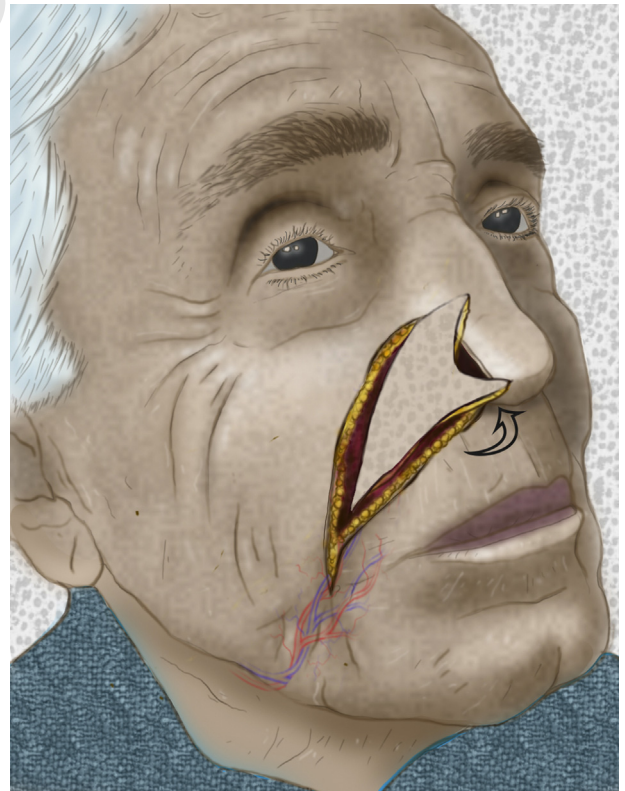


Fig. 4. Dissection of the flap and facial artery with preservation of the pericommissural perforators and advancement of the flap.

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