Repair of a Large Upper Lip and Malar Defect

Introduction

We describe a case in which the patient had undergone three previous conventional surgeries, with compromised margins, and already presented a distortion on the right side of the upper lip. For the reconstruction of this extensive defect, we propose an adequate alternative carried out in a single surgery and providing good aesthetic and functional results.

Case Report

A 69-year-old woman with micronodular basal cell carcinoma, located in the right nasolabial fold, after a history of three previous conventional surgeries resulting in compromised margins presented with retraction of the upper lip and a scar lesion in the right nasolabial fold, with a hardened region. Mohs micrographic surgery was performed in two stages with a final defect of 5.5 cm × 2.5 cm [Figure 1].

Due to the extensive final defect, at the end of two stages in the two-stage Mohs micrographic surgery, we needed to bring tissue from an area with tissue reserve that would make the direction of the tension vectors parallel to the lip opening, thus avoiding further distortion.

We opted for a finger-shaped transposition flap, which consisted of tissue from the preauricular/mandibular region transposing the malar region, with a rotation movement, and filling the extensive defect that affected the malar and perioral region. The donor area was marked with the same dimensions as the recipient area, the length being drawn in such a way as to avoid tension after the arc rotation of a pivot based on the mandibular region. The angle of rotation was approximately 90°, with subcutaneous oral fat preserving branches of the facial artery [Figure 2]. After flap positioning, sutures were performed in 2 planes, using monocryl 4.0 for the subcutaneous tissue and nylon 5.0 for the superficial portion. At 4-month follow-up, the patient was satisfied with the postoperative evolution [Figures 3 and 4].

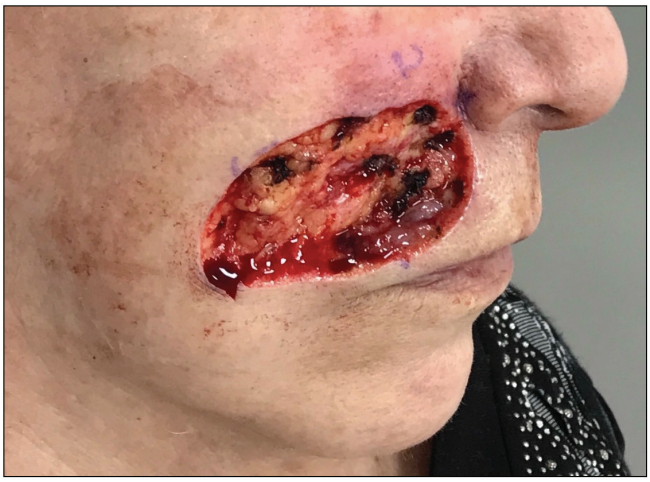

Figure 1: Surgical defect involving malar and perioral region, measuring 5.5 cm × 2.5 cm

Discussion

The transposition flap is an excellent option when there is a risk of functional and aesthetic impairment of the surgical defect if it is repaired by primary closure, skin graft, or secondary intention.[1]

By definition, the transposition flap must be elevated over a central area of normal skin to reach its final destination for the closure of the primary defect.[2] It is commonly used to repair skin defects in the head and neck regions. They have the advantage of being able to move a tissue reserve, redistributing the stress vectors to more favorable directions, leading the tension away from the primary defect. This is useful for repairing injuries that, if closed otherwise, could cause high levels of tension or distortion of anatomical structures.[1-3]

In the case described, the patient's lip distortion was due to the three previous surgeries with compromised margins. We opted for a transposition flap to reestablish tissue volume with skin from an area with greater reserve. The

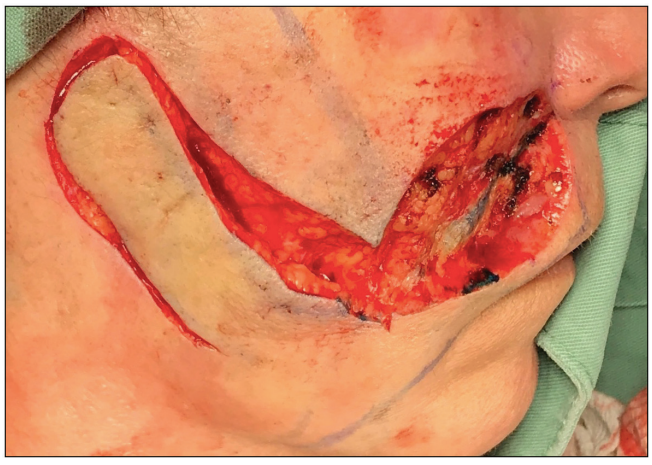

Figure 2: Transposition flap movement in a finger shaped closure

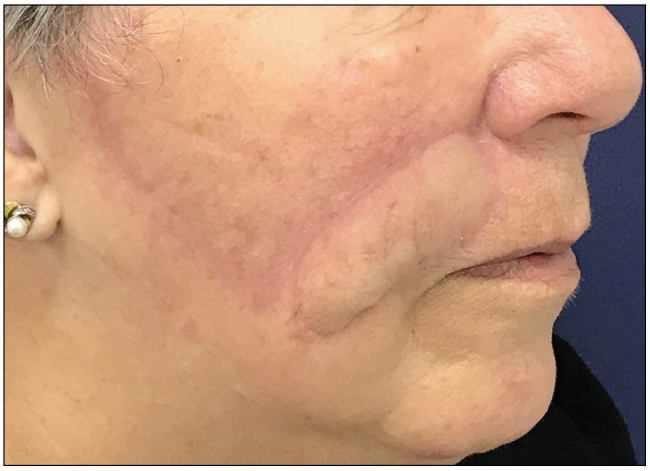

Figure 3: Result after 4 months (side view)

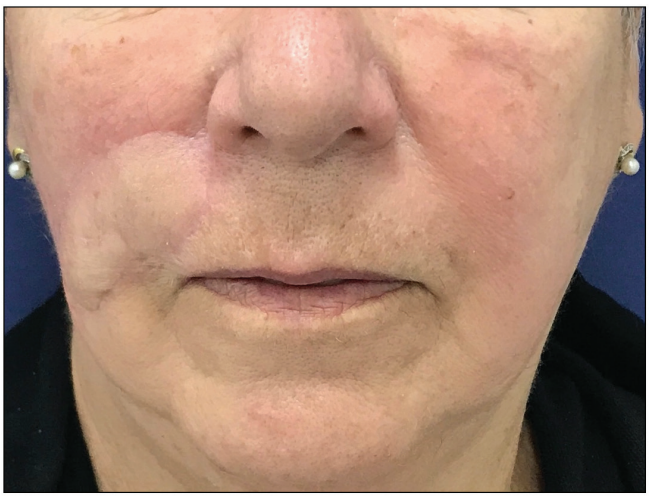

Figure 4: Result after 4 months (front view)

preauricular and mandibular region is a good option in these cases, also to avoid any additional scars in the central area of the face, as would happen with a bilobed flap of the malar region. The major final surgical defect was repaired with a unilobed finger-flap that redirected the tension from the perioral region to the mandibular region. It is important to note that due to the length of the flap, it is necessary to leave an adequate thickness of subcutaneous tissue (axial and perforating vessels) to allow for distal nutrition.

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Nil.

Conflicts of interest

There are no conflicts of interest.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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