Retalho Bilobado como Opção na Reconstrução de Grandes Defeitos Cervicais

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RESUMO – O retalho bilobado tem sido amplamente utilizado na reconstrução de defeitos cirúrgicos da porção distal do nariz. É um retalho local que recruta pele de áreas onde há relativa redundância para encerrar defeitos em zonas de pele relativamente menos móvel. Para além da sua utilidade na reconstrução de defeitos cirúrgicos nasais, pode ser utilizado para reconstruir grandes defeitos noutras regiões anatómicas. Apresentamos um caso clínico em que o retalho bilobado foi aplicado na reconstrução de um defeito cirúrgico resultante da excisão de um carcinoma basocelular de grandes dimensões da região cervical, com excelente resultado estético e funcional.
PALAVRAS-CHAVE – Neoplasias da Pele/cirurgia; Pescoço/cirurgia; Retalhos Cirúrgicos; Técnicas de Encerramento de Ferimentos.

The Bilobed Flap as an Option for Large Neck

ABSTRACT – *The bilobed flap has been extensively used in the reconstruction of distal nasal defects. It is a local flap that recruits skin from areas where there is relative skin mobility to close defects in areas where the skin has less plasticity. Besides its usefulness in the reconstruction of small to moderate cutaneous nasal defects it can also be used to reconstruct large defects located in other anatomical areas. We present a clinical case in which the bilobed skin flap was employed to reconstruct a large surgical defect of the neck resulting from excision of a basal cell carcinoma, with excellent functional and cosmetic results.*
KEYWORDS – *Neck/surgery; Skin Neoplasms/surgery; Surgical Flaps; Wound Closure Techniques.*

INTRODUCTION

The management of extensive head, neck and facial defects is complex, and a wide range of management options is available. Primary closure of the defect is not always feasible and skin grafting or local flaps are thus necessary.[1,2]

The bilobed flap is a double transposition flap that is designed to recruit adjacent skin and soft tissue from areas of laxity to areas of skin deficiency. It is commonly used in small-to-medium size skin defects of the face, particularly of the nose, where skin is less mobile.[2-4] It was first described by Esser in 1918 for nasal tip reconstruction[1,2,5] and in 1953, Zimany optimized Esser's bilobed flap and applied it to a variety of reconstructive situations.[1,4,6]

Herein, we report a case of a bilobed flap reconstruction in a patient with a large defect of the lateral portion of the neck following a basal cell carcinoma (BCC) excision.

CASE REPORT

A 78-year old male patient was referred to our Dermatologic Surgery Department due to an ulcerated and infiltrative BCC on the left superior portion of the nucha, behind the earlobe, which had already been confirmed by histology of a punch biopsy. The lesion presented as an ulcerated round tumour measuring 6 cm in diameter (Fig. 1 A).

Under local anaesthesia, resection of the lesion to the level of the muscular fascia and with 1 cm safety margin was performed, resulting in an 8 cm wide surgical defect (Fig. 1 B). Immediate reconstruction with a bilobed flap from the lateral aspect of the neck was conducted (Fig. 1 C-E). The lobes were medially based with decreasing lobe size, considering the original defect size. The flap was elevated and rotated with the axis of rotation and pivot point located along a line tangential to the outer perimeter of the

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Pérolas Cirúrgicas

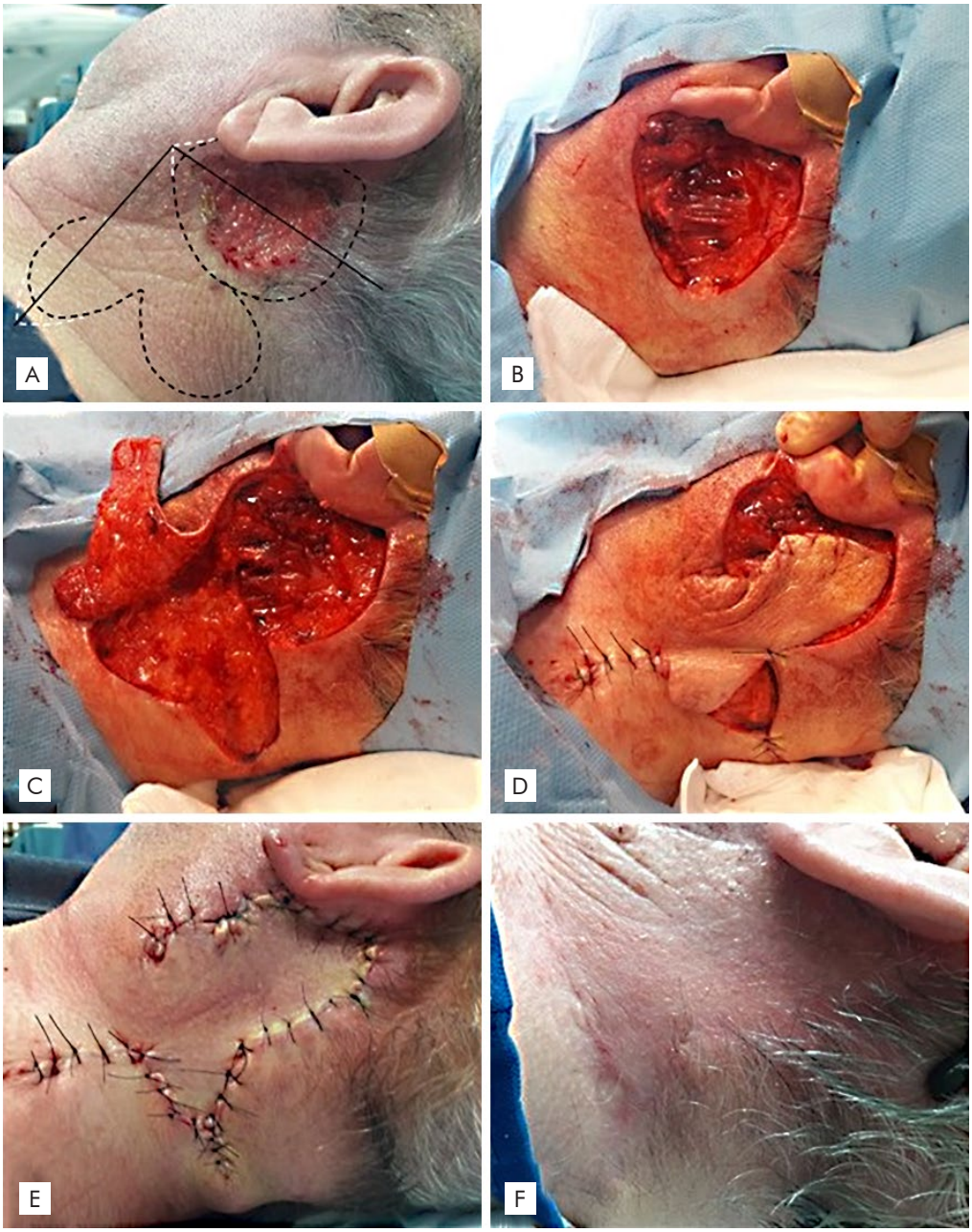

Figure 1 - (A) Clinical picture of an ulcerated and infiltrative basal cell carcinoma in the lateral cervical area and schematic representation of the anticipated defect and planned medially based bilobed flap. **(B)** Surgical excision with a resulting 8 cm wide surgical defect. **(C-E)** Reconstruction of the surgical defect with a local bilobed flap. **(F)** Clinical picture at 3 months follow-up, after surgery.

original defect. The terminal donor site was closed primarily. The primary flap was inset first. Tacking sutures with a deep 3-0 synthetic absorbable suture were placed into the bed of the defect and then into the primary flap. The secondary defect was partially closed directly (at the distal end) in order to reduce its size thus allowing better fitting of the secondary flap. The secondary flap was trimmed to fit the remaining defect precisely and inset in a similar fashion to the primary flap. The skin was then closed with a simple suture using a 3-0 nonabsorbable, sterile monofilament.

There were no postoperative complications and the flap healed in a satisfactory manner, with excellent functional and cosmetic outcomes (Fig. 1 F).

DISCUSSION

The bilobed flap recruits skin that is not immediately adjacent to the surgical defect, offering a greater amount of available tissue for total reconstruction in many anatomical

areas.[2-4] The flap design allows for a reduced arch of rotation which is a valuable surgical option, particularly for the head and neck region where skin mobility is limited.[2,3,5] Since it is a local flap it results in excellent matching of the skin in terms of colour, texture and thickness which are similar to the adjacent skin.[2-4]

As such, the bilobed flap is a very common surgical procedure used to cover small defects on the face, with excellent clinical outcomes.[2,3,7] It is a versatile skin flap, increasingly used in other anatomical locations.[1,4-6] This clinical case demonstrates that the bilobed flap is a good option for single stage closure of larger defects of the neck avoiding the need of tissue expanders, free tissue transfers or skin grafts. In addition to the simplicity of the procedure, good aesthetic and functional results are achieved.

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