

RECONSTRUÇÃO COMPLEXA DE DEFEITO DO TERÇO INFERIOR DO NARIZ

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RESUMO – A reconstrução de defeitos nasais deve preservar a integridade das funções e expressões faciais. A localização do tumor, o tamanho, as camadas atingidas e a disponibilidade de tecido dador devem ser considerados, de modo a estabelecer o procedimento cirúrgico adequado. Em qualquer reconstrução nasal, é necessário ter em conta três camadas: revestimento interno, suporte cartilágneo e revestimento externo.

Os autores descrevem a reconstrução de um defeito de espessura total do terço inferior do nariz após excisão de carcinoma basocelular recidivado, com retalho septal mucoso ipsilateral para a reconstrução do revestimento interno, enxerto livre de cartilagem auricular para o suporte cartilágneo e retalho de transposição nasogeniano para o revestimento externo, num único tempo cirúrgico e com resultado estético e funcional final aceitável.

PALAVRAS-CHAVE – Reconstrução nasal; Enxerto cartilágneo; Revestimento mucoso; Retalho de transposição nasogeniano; Carcinoma basocelular.

COMPLEX RECONSTRUCTION OF DEFECT OF THE LOWER THIRD OF THE NOSE

ABSTRACT – Reconstruction of nasal defects must preserve the integrity of complex facial functions and expressions, as well as facial symmetry and a pleasing aesthetic outcome. The localization and size, the anatomical layers involved and the donor tissue availability must be considered in order to establish the indication of the proper surgical procedure. In any nasal reconstruction, it is necessary to take into account three layers: internal lining, cartilaginous framework and external covering.

The authors describe the reconstruction of a full-thickness defect of the left lower third of the nose after excision of a recurrent basal cell carcinoma, with ipsilateral septal mucosal flap for reconstruction of the internal lining, free auricular cartilage graft for reconstruction of cartilaginous framework and nasolabial transposition flap for the external coating, in a unique surgical procedure and with acceptable functional and aesthetic final results.

KEY-WORDS – Rhinoplasty; Nose deformities, acquired; Surgical flaps; Carcinoma, basal cell.

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INTRODUCTION

The prevalence of skin cancer involving the nose as well as its increased incidence render nasal reconstruction as one of the most common challenging surgical procedure^{1,2}. Given the vital functions of the nose, it is extremely important that the reconstruction of facial defects preserves the integrity of complex facial functions and expressions^{1,3}. The function of the nose must be maintained by replacing the cartilaginous framework and the mucosal lining, never compromising a patent airway^{1,3}. Re-establishing the framework in nasal reconstruction is critical to achieve form and function. Numerous flaps have been designed to provide coverage of a variety of nasal defects.

CASE REPORT

We describe a 72-year-old male patient who was observed with a relapse of basal cell carcinoma located on the lower third of the nose. The tumor was infiltrated, with centrally ulcerated plaque, unclearly delimited borders (Fig. 1). The histological analysis of an incisional biopsy was consistent with an ulcerated basal cell carcinoma. The radical excision of the tumor with about 3mm surgical margins and under local anesthesia, provided a full-thickness defect, measuring approximately 2.5cm and occupying several subunits of the nose such as the left soft triangle, portions of the left dorsal sidewall, the tip, the ala and the distal portion of the dorsum (Fig. 2A).

A bipedicle flap of nasal mucosa just superior to the defect was employed to restore the nostril lining margin (Fig. 2B). A free cartilage graft was harvested from the posterior conchal bowl of the ear. The cartilage graft was positioned to create an alar batten anastomosed to the defect (Fig. 2C). The donor site was closed primarily. Then, a nasolabial transposition flap with a superiorly based was realized (Fig. 3). The surgical procedure

was performed in a single stage without intercurrents. Postoperative complications were not reported and the nasal function was totally preserved. There were a slightly "dog ear" in the nasal dorsum, but the patient didn't wanted a surgical correction (Fig. 4).



Fig. 1 - Recurrent basal cell carcinoma, ulcerated on the lower third of the nose.

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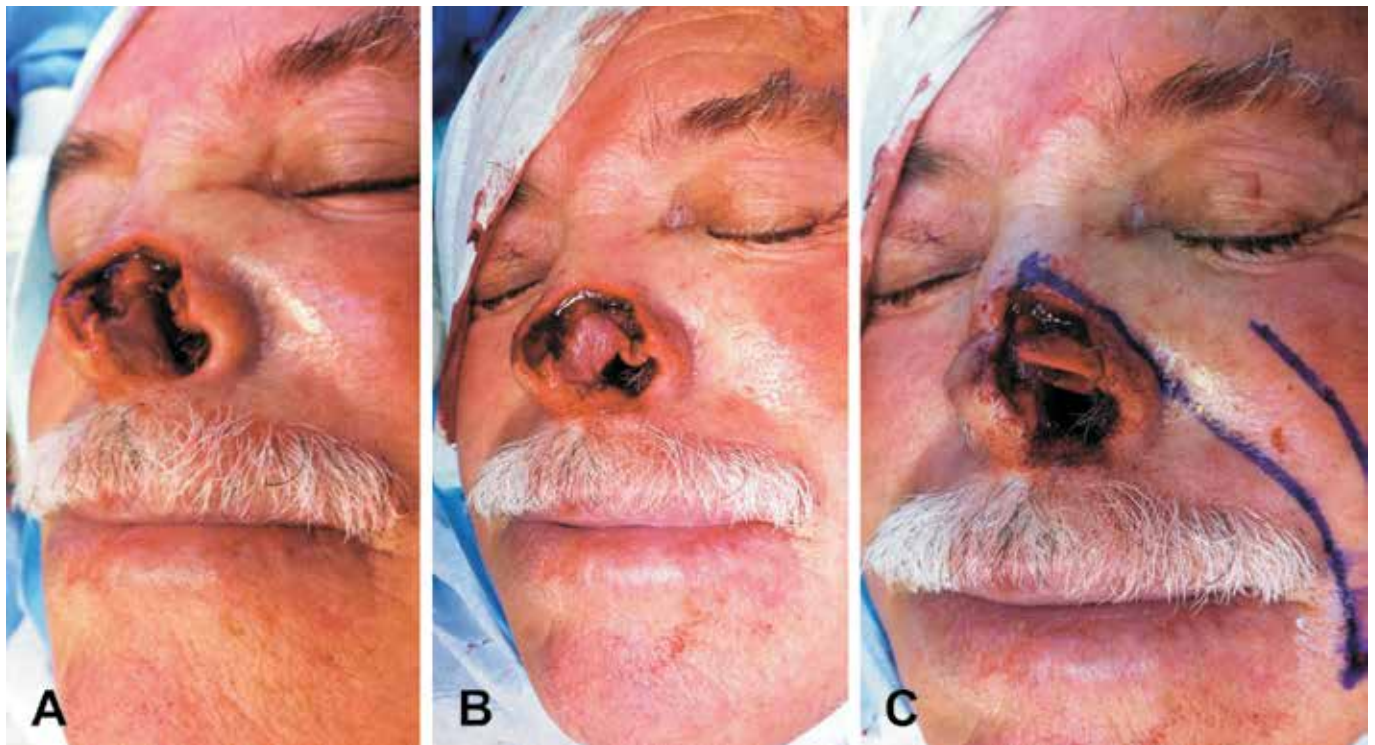


Fig 2 - A) Surgical defect occupying several subunits of the nose; **B)** Internal lining with ipsilateral septal mucosal flap; **C)** Free cartilage graft from the concha in position.



Fig 3 - Nasolabial transposition flap.

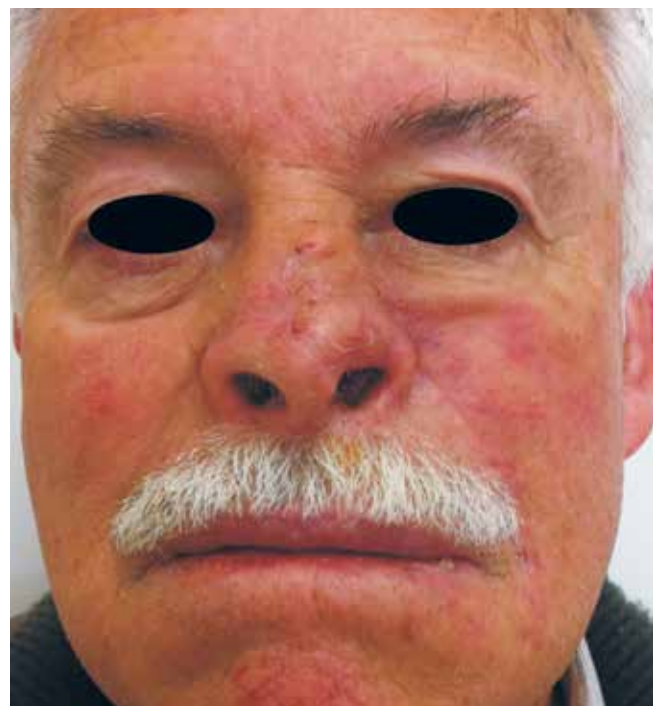


Fig 4 - Results after 1 month with slightly "ear dog".

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DISCUSSION

A basic premise of nasal reconstruction dictates that missing tissue should be replaced with similar tissue harvested from adjacent or remote locations. Accordingly, difficult full-thickness alar wounds often require nasal mucosal replacement for lining, cartilage batten graft support for the preservation of nasal function, and skin coverage for the restoration of an aesthetically proper appearance⁴. Intranasal mucosal flaps are the preferred method for many full-thickness defects because they replace tissue with like tissue. The ipsilateral septal mucosal flap is one of the most frequently used in the inner lining flaps to the bottom third of the nose allowing good vascularization at higher lip artery branch^{1,5}. Thereby, it makes possible the use of primary cartilage grafts from the ear without risk of cartilage necrosis⁵.

Millard has emphasized that the major function of framework is to achieve and maintain profile and patency of the airways. This result was obtained through the auricular conchal cartilage graft which is more used due to its easy access. Numerous skin flaps have been described for nasal reconstruction. The nasolabial flap is a superiorly based transposition flap, ideally suited for reconstruction of small- to medium-sized defects involving the lateral aspect of the nose. Depending on the laxity of the cheek tissue, the width of the nasal wound to be reconstructed with this graft is usually limited to less than 2,5cm⁷. This flap offers many advantages: good color and texture match for nasal tissue, abundant reservoir of tissue laxity from the medial cheek, donor site scar well hidden along the melolabial fold, and adaptability as a single-stage procedure. Furthermore, the skin is usually free of hair

and has an excellent blood supply from the branches of the facial artery. The skin implemented is very similar to that which was present due to its proximity¹. But its underlying fat has a strong tendency to contract. Wounds of the nasal tip or nasal dorsum require a long nasolabial flap and are more likely to develop trapdoor deformity or tip necrosis. For wounds, larger than 2,5cm, other reconstructive options, such as a forehead flap. In this case, a paramedian forehead flap could have been performed but would have needed a two-staged. We emphasize this case because of the good aesthetic and functional results achieved with the combination of ipsilateral septal mucosal flap, free auricular cartilage graft and nasolabial transposition flap, in a unique surgical procedure.

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