

Modified island flap for basal cell carcinoma of the nasal apex

Simona Kordeva,¹ Georgi Tchernev^{1,2}

¹Clinic for Dermatology, Venereology and Dermatologic Surgery “Onkoderma”, Sofia; ²Department of Dermatology and Venereology, Medical Institute of Ministry of Interior, Sofia, Bulgaria

The case

An 80-year-old female presented with an atrophic lesion in the area of the nasal apex, dating for the past 5-6 years. The lesion had a superficial telangiectasias and a pearly edge, measuring 1 cm in diameter. The patient denies painful sunburns in the past. Previous history of basal cell carcinomas located on the temporal and sacral regions. A clinical diagnosis of basal cell carcinoma was established, and the patient was advised to consider surgical removal of the lesion as a recommended course of action (Figure 1).

How would you remove the lesion?



Figure 1. Clinical diagnosis of basal cell carcinoma.

Our choice

For this lesion we decided to perform an oval excision, ensuring a surgical safety margin of 0.3 cm in all directions. Then contouring of a triangle in the proximal direction from the nasal apex was crafted, followed by a transposition of the prepared triangle to the nasal apex. The adaptation of wound edges included extending and excising a segment of the skin to the right of the patient. The final step involved closing the defect with single interrupted sutures (Figure 2).

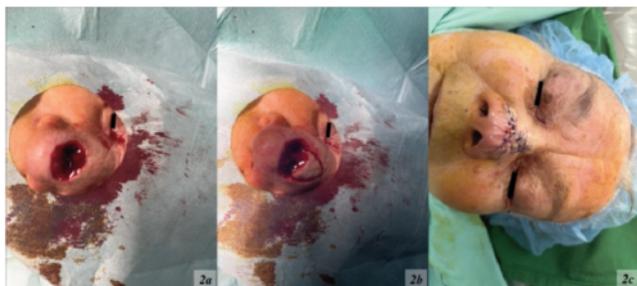


Figure 2. Closing the defect with single interrupted sutures.

Comment

Achieving a complete comprehensive tumor excision, while optimizing both functional and aesthetic outcomes, is considered a primary goal in the dermatosurgical field.¹ Different approaches to reconstruction, including secondary healing and the use of flaps, are applied to address defects in the perinasal or facial region that may arise following trauma or tumor surgery.¹ Secondary healing should be avoided in the nasal apex, as it can result in delayed healing and uneven scarring.²

Restoring nasal defects following skin tumor removal can be challenging due to the complex three-dimensional nature of the nose.³ The complexity of the process is further heightened by the necessity of achieving an aesthetically pleasing postoperative result.³

In our case, opting for a modified transposition flap not only spared us from a second intervention or an overly invasive procedure but also addressed the challenging reconstruction of the area. While conventional methods involve the use of split skin mesh or full-thickness mesh grafts, the downside lies in the visibility of the skin graft. In contrast, our modified island flap leaves no visible defects, presenting a more aesthetically pleasing solution.

The outcome

Figure 3.



Figure 3. One-month follow-up. a) frontal view; b) lateral view..

References

1. Tchernev G, Gianfaldoni S, Wollina U, et al. Dermatosurgery rounds - The Island SKIN Infraorbital Flap. Open Access Maced J Med Sci 2017;5:554-5.
2. Mott KJ, Clark DP, Stelljes LS. Regional variation in wound contraction of Mohs surgery defects allowed to heal by second intention. Dermatol Surg 2003;29:712-22.
3. Tchernev G, Temelkova I, Mangarov H, Stavrov K. Comparative Analysis of the applicability of island flap in primary and recurrent basal cell carcinomas of similar localization. Open Access Maced J Med Sci 2018;6:1077-80.

Non-commercial use only