

Case Report

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Bilobed Flap: A Surgical Alternative in Nasal Ulcerated Basal Cell Carcinoma

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ABSTRACT

Basal cell carcinoma was first described by Jacob in 1827 as a very slow-growing ulcer on the face, with peculiar edges reminiscent of a rat bite, which is why it was called “Ulcus Rodens” and over time it has received various denominations. Basal cell carcinomas: are defined as malignant epithelial tumors located in the skin, arising from pluripotent cells in the basal area of the epidermis and the external root sheath of the hair at the level of the lower isthmus and pons. They are slow growing, rarely produce metastases, have local destructive capacity, and compromise extensive areas of tissue, cartilage and even bone. They develop in photo-exposed areas of individuals with a light phototype, between the third and sixth decade of life. Treatment for patients with basal cell carcinoma includes: surgical and non-surgical options, among surgical options, excision is the standard therapy, considered effective since it has cure rates of 9 to 95% at 5 years; which is why it was the treatment chosen for our case with subsequent reconstruction of the surgical defect. For surgical reconstruction, several types of flaps can be proposed, including the bilobed flap, which is a double transposition flap that shares a single base.

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Clinical Case

A 72-year-old female patient, a housewife, resident of Carabobo, Venezuela, was diagnosed with systemic arterial hypertension in 2000 and is currently undergoing treatment with 50 mg losartan potassium. She attended the Dermatology Department of the Dr. Enrique Tejera Hospital City due to a dermatosis located on the right nasal wing and lateral wall, characterized by an erythematous neoformation with regular, well-defined, elevated, translucent edges, with telangiectasias on its surface and a central ulceration, approximately 0.6 mm in diameter, which had been developing for 6 months (Figure 1A).



Figure 1A: On the tip, wing and right lateral wall of the nose, an erythematous neoformation is evident, with regular, well-defined, raised, translucent edges, with telangiectasias on its surface and central ulceration, 0.6 mm in diameter.

Polarized light dermatoscopy reveals: erythematous background, ovoid nests, arborescent vessels, central ulceration and erosions.

For the above reason it was carried out Excisional biopsy for histopathological diagnosis followed by immediate reconstruction with a bilobed transposition flap.

In block resection of the lesion was performed after marking with 0.7 mm oncological margins (Figure 1B), leaving a 13 mm defect encompassing three aesthetic subunits: nasal tip, lateral wall, and nasal ala, with immediate reconstruction with an inferior-based bilobed transposition flap (Figure 1C).



Figure: 1B



Figure: 1C

Histopathological examination revealed a dermal tumor consisting of a proliferation of small basaloid cells grouped into solid islets arranged in a palisaded pattern toward the periphery. The diagnosis was therefore ulcerated basal cell carcinoma of the nose (Figure 2).

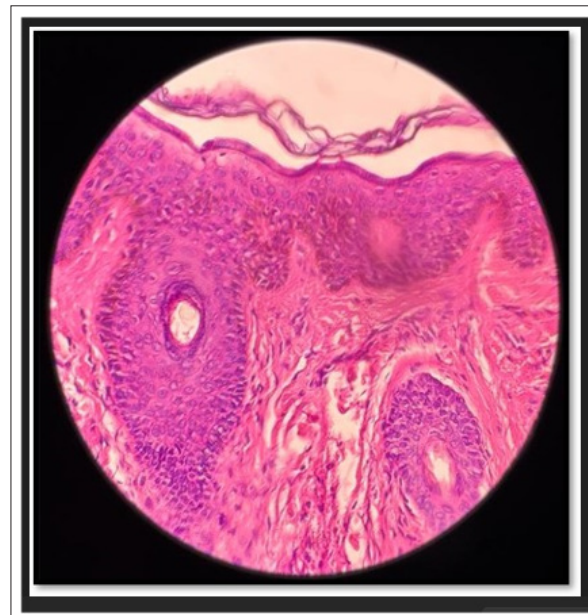
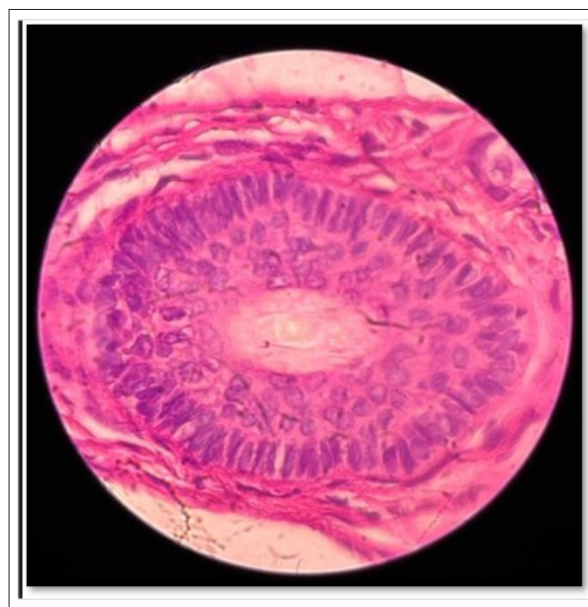


Figure 2: Histological slide of skin stained with hematoxylin and eosin at 40 and 100x respectively shows: dermal tumor formed by a proliferation of small basaloid cells. Grouped in solid islets with a palisade arrangement towards the periphery of the same.

At the resection margins, the patient is free of neoplastic infiltration and has shown excellent clinical progress (Figure 3).

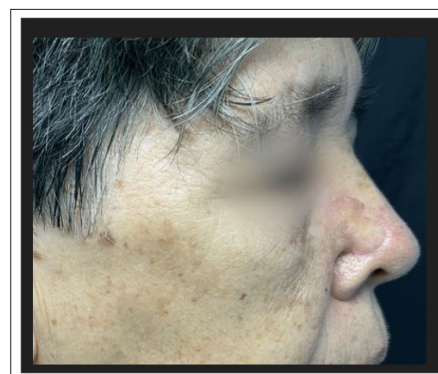


Figure 3: Patient's Evolution 3 Months After Surgery

Discussion

Basal cell carcinoma also called Darier's Malpighian epithelioma, Foot and Masson's adnexal epithelioma, basalioma and basal cell epithelioma. It constitutes 80-90% of all skin cancers and is the most frequent tumor in humans, originating from undifferentiated and pluripotent cells of the epidermal basal layer [1]. Basal cell carcinoma is characterized by being a slow-growing and mostly locally invasive tumor. Although it rarely causes death or metastasis, its existence produces high morbidity. Regarding clinical manifestation, basal cell carcinoma usually affects photoexposed areas; the head and neck are the main site in 80% of cases, followed by the trunk in 15%, the extremities can also be affected [2]. Treatment includes: surgical and non-surgical options including topical imiquimod, 5-fluorouracil (5-FU), photodynamic therapy (PDT), intralesional interferon, radiotherapy and Hedgehog pathway inhibitor drugs, and in surgical cases, excision is the standard therapy, considered effective since it has cure rates of 9 to 95% of cases at 5 years, with surgical margins of 4 to 5 mm [3]. Reason why it was the treatment chosen for our case with subsequent reconstruction of the surgical defect.

The nose is a very common area for basal cell carcinomas. Therefore, the reconstruction of surgical defects of the nasal pyramid, whether after standard surgery or Mohs micrographic surgery, is a challenge that any dermatologist must undertake.

The choice of reconstructive procedure will depend on several factors, such as the location, size, shape, and orientation of the defect, the quality and availability of surrounding tissue, and the specific characteristics of each patient, such as age, sex, associated pathology, smoking, occupation, expectations, and especially deformities that involve asymmetry. When approaching the nasal wings and nostrils, airway patency must be preserved [4-6].

In general terms, for small defects up to 5 mm, primary closure is possible; medium-sized defects (6 to 20 mm) can be repaired with local flaps, and for defects larger than 20 mm, regional flaps are required, including the bilobed flap, which was first described by Esser in 1918 and modified by Zitelli in 1989. Mainly used in the reconstruction of the distal third of the nasal pyramid, this is a double transposition flap that shares a single base, consisting of a first lobe close to the defect that is mobilized to cover it and the second lobe covers the defect left by the first, finally, the final loan, which is closed edge to edge. This type of flap is ideal in patients with thin, lax skin, whose laxity can be tested by the surgeon by pinching the nasal skin between the thumb and index finger [7,8].

Conclusion

The bilobed flap is a surgical reconstruction technique for nasal pyramid defects that is satisfactory and effective in the long term due to its aesthetic and functional results, as demonstrated in our patient. It provides coverage adjacent to the defect, allows for better tension distribution, helps minimize distortion, and can be performed in a single surgical procedure on an outpatient basis.

Conflicts of Interest

No conflicts of interest reported

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