



Bilateral Primary Commissuroplasty and Primary Repair for Lower Lip Defect (30% to 80%) after Cancer Excision

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Abstract

Introduction: Lip reconstruction is an essential step in lip tumors. In this regard, there are many procedures with good outcomes. Flap problems are the possibility of necrosis and an extensive suture line that wrecks aesthetics. Our technique has no flaps for defects more than 30% of the lip, and the suture line is minimal.

Methods: This study is a surgical technique report from a single center. The original technique was based on our experience with about 100 patients in 25 years. But in this study, 10 patients were included. After excising the tumor, a bilateral 10 mm to 15 mm horizontal skin incision beginning from the commissures to lateral sides was made. The skin and mucosa were dissected from the underlying orbicularis muscle, and the muscle was partially cut about 15 mm from each side. Then the remaining sides of the lip were advanced and repaired in three layers. Finally, the released mucosa was sutured to the angle of incised skin.

Results: The patients were followed for at least three years. Oral competence was good, mobility and sensation were well preserved, the scars were less than other flaps, and the aesthetic was satisfying. The patients did not have drooling, flap edema, and pin cushioning.

Conclusion: Among various techniques for lower lip reconstruction, the presented technique in this study seems to be safe and straightforward, but to measure all aspects of it, other surgeons need to use this method and express their opinions.

Keywords: Lip neoplasms; Reconstruction; Lower lip; Primary repair

Introduction

The lips have essential and diverse function including oral competence, deglutition, articulation, and expression of emotion. The lips are brought together to close the mouth by the role of the orbicularis oris, a complex sphincter muscle [1]. Some of the muscle fibers of the orbicularis oris derive from intrinsic fibers of the lips, whereas others derive from other facial muscles that insert into the lips [2,3]. Depression and retraction of the lower lip are mainly controlled by the platysma, depressor labii inferioris, and depressor angulioris muscles. The primary motor nerves of the lips are the buccal and marginal mandibular rami of the facial nerve. The marginal mandibular supplies the lower lip depressors. Sensory innervation of the lips is *via* the infra-orbital and mental branches of the trigeminal nerve and supplies from superior and inferior labial arteries, with venous drainage to the anterior facial vein lymphatic drainage is through sub-mental and submandibular lymph nodes [2]. Researchers have described many reconstructive techniques to overcome significant defects, such as "cross-flap" developed by Abbe et al. [4] and Estlander et al. [5], using the opposite lip with the various modifications suggested [6,7], and Karapandzic technique [8]. This technique provides the excellent advantage of preserving the nerves and blood vessels of the flaps and allows an excellent sphincteric function to be maintained [9,10]. Bernard-Burow's method and other versions (fan-flap procedure) are also useful in cases with more lip gloss [11]. The purpose of lip reconstruction is to maintain oral competence, mobility and sensation, and obtain the best aesthetic results. When

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the size of stoma, becomes less than 50% after reconstruction, can be problematic for those who wear dentures. Maintaining harmony, symmetry, and adequate size is critical for cosmesis [12]. It is necessary to repair the sphincter ring using all four layers (mucosa, muscle, subcutaneous tissue, and skin) at the same time after excision [13]. Reconstruction should provide an adequate oral opening and mucosa adjacent to the commissure to avoid contracture [4,14]. The present study aimed at investigating a new technique for lower lip reconstruction after tumor excision resulting in a medium-size defect.

Methods

This study is a surgical technique report from a single center. The original technique was based on our experience with about 100 patients in 25 years. A total of 10 patients who were referred to our hospital from 2105 to 2018 were participating in this study and they were followed up for three years. The original technique was based on our experience with about 100 patients in 25 years. Informed consent was obtained from patients before participation in the study. Lower lip defects occurred in all patients following squamous cell carcinoma excision. The patients were in stage 3 of TNM classification and none of them had positive lymph nodes. No antibiotics were given before surgery.

Surgical Technique

Wide local excision of the lower lip tumors was performed under general anesthesia. Reconstruction was undertaken after the margins were shown to be free of cancer by frozen sections. In this technique, the lower lip defect will primarily be repaired even if the defect was more than 30% of the lip. After excising the tumor, a bilateral 10 mm to 15 mm horizontal skin incision begins from the commissures to lateral sides (Figure 1A). Then the skin and mucosa will be dissected from the underlying orbicularis muscle, and the muscle cut partially about 15 mm on each side (Figure 1B). Commonly no vessels needed to be ligated and back cut. Two sides of the lip will be advanced and sutured in three layers separately (Figure 1C). Finally, the median of the dissected mucosa in the commissures will be sutured to the angle of incised skin. Then completing mucosa to skin suturing (Figure 1C).

Results

The technique used in this study has a history of 25 years' experience and almost as not had any complications in these few years. Since our data during those 25 years is not complete, we have

conducted the study on 10 patients. The patients included 2 female and 8 males with the mean age of 61 years old. The defect size was all above 50% except one case. Five patients had hypertension and 5 had diabetes mellitus (Table 1). The average operation time was about 70 min. Sutures were drawn between 5 and 7 days. Early and late postoperative results were satisfactory. No second surgery for modification was needed. At a 3-year follow-up, the patients were doing well with excellent functional and aesthetic outcomes and there was no recurrence. Lip apertures and movements were normal, with sufficient mouth opening and oral competence and good volume and quality of the vermillion. The patients have no complaint of drooling. Speech and sensation were preserved, and highly pleased with the outcome. Figure 2 shows a case in pre-surgical and post-surgical.

Discussion

There are many surgical techniques for the reconstruction of the lower lip. The results of the traditional methods have been adequate and sometimes excellent, especially in elderly patients with thin lips. However, the patients, especially young patients, have suboptimal aesthetic problems. For defects less than 30%, a primary repair is an acceptable option, and it's not challenging. For defects of more than 30% of the lower lip, which is the most challenging between surgeons, several flaps are proposed: The Abbe flap [15], the neurovascular Karapandzic flap [8], and Bernard-Webster flap [16]. For more significant defects, not including the angles of the mouth, Gillies's fan is a good choice [17]. One of the choices for Defects involving the commissure is the Estlander flap [5]. All of them have advantages and disadvantages. In the case of local flaps, flap loss, blunting of the repaired commissure, lip asymmetry, sensory loss, hypersensitivity, edema, microstomia, poor oral competence with drooling, undesirable scarring, and flap necrosis must be considered. The Karapandzic flap has the potential risk of microstomia and blunting of the oral commissure [18]. With Karapandzic flap, we have to maintain lip mobility with preserved sensation and competence, but reconstruction of significant defects inevitably results in microstomia, necessitating secondary commissuroplasty [19]. The Webster-Bernard procedure using cheek advancement flaps can give an appropriate lip reconstruction but involves a sizeable perioral tissue loss. Also, it has significant perioral scarring with contour deformity [20]. In addition, effacement of gingivobuccal sulcus and notching of the central lip have been described as common aesthetic disadvantages [21]. In the Estlander flap, rotation of a lateral area of

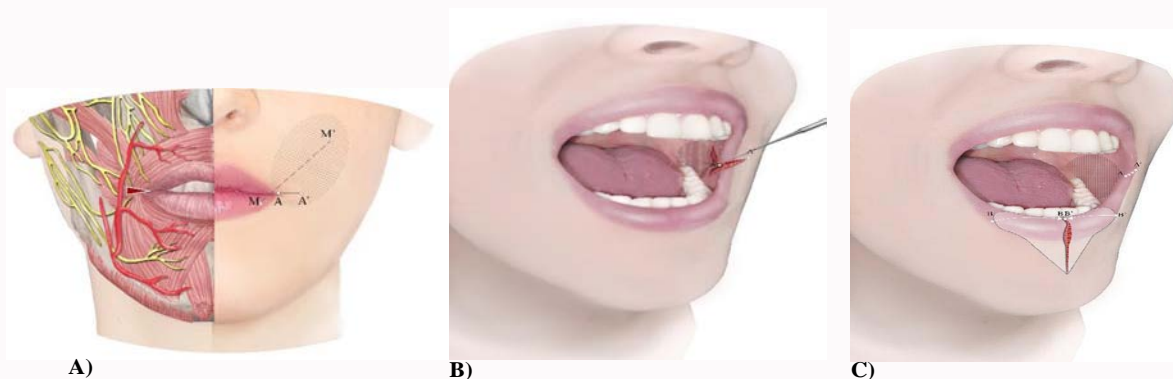
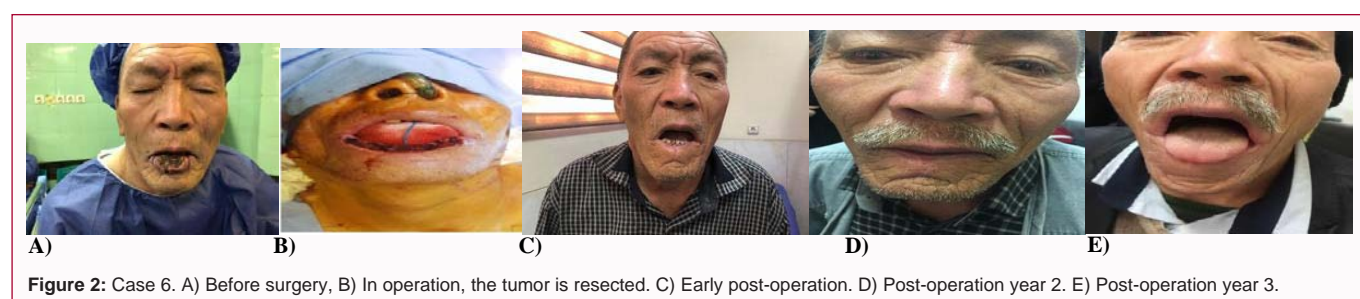


Figure 1: Surgery steps. All the incisions were bilaterally, but we made the incisions on one side to show inside the mouth in the pictures. A) First, an incision is made from A to A1. Then, an M to M1 incision will be made in the mouth. B) The muscle has been excised from the skin and mucosa and then back cut. C) Two sides of the lip will be approximated and sutured in three layers separately. The median of the dissected mucosa in the commissure sutured to the angle of incised skin from A to A1.

Table 1: Demographic data of the patients.

Cases	Age	Sex	Etiology	Defect size	Follow up period	HTN	DM	Complication	Recurrence after 3 years
1	48	M	SCC	50%	36 months	-	-	None	None
2	52	F	SCC	65%	36 months	-	-	None	None
3	50	F	SCC	70%	24 months	-	+	None	None
4	68	M	SCC	60%	36 months	+	+	None	None
5	62	M	SCC	70%	36 months	+	-	None	None
6	65	M	SCC	80%	36 months	+	+	None	None
7	71	M	SCC	40%	36 months	+	-	None	None
8	75	M	SCC	55%	36 months	+	+	None	None
9	60	M	SCC	65%	36 months	-	+	None	None
10	58	M	SCC	70%	36 months	-	-	None	None

**Figure 2:** Case 6. A) Before surgery, B) In operation, the tumor is resected. C) Early post-operation. D) Post-operation year 2. E) Post-operation year 3.

the upper lip to the commissure is done first, and a second surgery is necessary to reconstruct the commissure angle. Therefore, it needs two operations. The Gillies fan flap has enough tissue to repair with no tension, but the commissure is distorted and becomes blunted, and the lower lip gets short [22]. Also, it has a long suture line, distorting the cosmesis. Analysis for aesthetic results was based on those with pre-and postoperative photographs. Oral competence was measured by muscular integrity and aperture. The orbicularis muscle was partially cut and correctly functioned, and the muscular integrity was preserved. The aperture and mobility were patient-reporting and asked by dentures and eating problem when eating by spoons or big morsels. No drooling was reported, and the severity of drooling was measured by the Blasco index [23]. Fortunately, none of the above problems were reported by patients. And over all the oral competence was good.

Among various techniques for lower lip reconstruction, this technique seems to be safe and straightforward, but to measure all aspects of it, other surgeons need to use this method and express their opinions.

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