

Rotational flap technique for a sizable lesion of the temple

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The case

A 50-year-old woman presented with a 2 cm large lesion on her right temple. A clinical diagnosis of partially pigmented basal cell carcinoma was established, leading to the planning of a subsequent excision.

How would you remove this temple lesion?



Our choice

After ensuring histological control of the margins, we proceeded with delayed surgery. Our approach involved the utilization of a rotation flap to effectively close the surgical defect.



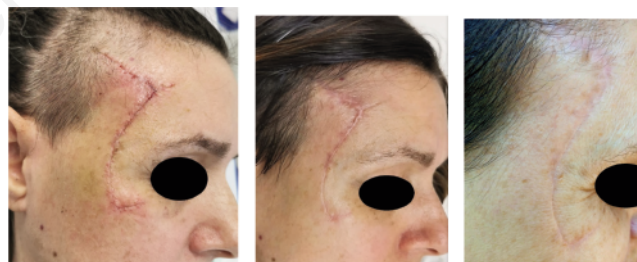
Design, flap preparation, excision and suture.

Comment

Rotation flaps are fashioned with a curved shape that aligns with the direction of the defect they are rotated into. The arciform incision facilitates the acquisition of laxity from adjacent tissues and redirects it to effectively close the surgical defect. Additionally, rotation flaps exhibit versatility by enabling the repositioning of dog-ears to the most suitable locations.¹⁻³

We opted for a rotational flap due to the lesion's positioning between the temporal and frontal areas, resulting in tension lines resembling an arch shape. Notably, the apex of the triangular defect was situated upward within the scalp's skin, as opposed to downward into the eyebrow area. This strategic placement ensured that the majority of the primary defect scar would be concealed within the hair-bearing skin.

During the procedure, given the substantial tension encountered, we introduced an excision line on the frontal aspect of the skin defect to alleviate tension. Ultimately, the resulting outcome was achieved through a combination of a rotational flap applied to the temporal aspect and a partial advancement flap on the frontal area. This approach effectively minimized tension within the surgical wound, consequently contributing to an improved overall outcome.



Outcome: follow up at 15 days, 2 months and 4 months.

References

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