INTRODUCTION

• The lower third of nose is a prominent structure vulnerable to cutaneous malignancies.¹
• From a reconstructive standpoint, the ala has always represented a uniquely challenging area to repair due to functional loss and loss of aesthetic appeal.

METHODS

• To date, three patients have been reconstructed. All procedures were performed by the same surgeon (R.W.W) between 2008 and 2010.
• Pedicled flap based upon perforators from the lateral nasal artery. Subperiosteal dissection over the lateral nasal wall and dorsum, we were able to achieve excellent color, texture, and symmetry matches in three patients over a 2-year period at an academic surgical center.

DISCUSSION

• Nasal reconstruction can be associated with distortion of crucial landmarks and meticulous care must go into flap design, vectors of tension, and soft tissue dissection.
• Several approaches to alar lobule defect repair have been described with the following limitations noted: 2, 3, 4, 5

• Skin graft: Flap failure, postoperative dehiscence/atrophy
• Bilobed and Rhomboid flap: Searing over multiple nasal subunits, dog-ear deformities.
• Reiger and forehead flap: Bulking relative to alternative techniques

• Advancing cheek and nasolabial flap: Obliteration effacement of the supra-alar crease.
• Pedicled flaps taken from the lateral nasal sidewall have not been described.

• By incorporating a random but robust subcutaneous pedicle, we were able to move the donor site to a less conspicuous area.
• The donor site morbidity is significantly reduced with this alternate skin paddle location.
• Due to the length of the subcutaneous pedicle, a larger arc of rotation is also achieved.
• The donor site is also ideal in terms of color, texture, and uncomplicated closure.

• Subperiosteal and subperichondrial tunneling along the lateral nasal wall and dorsum minimizes deformity of the adjacent nasal and cheek regions.
• For alar defects up to 1.5 cm sparing the supra-alar crease just above the nasal superficial muscular aponeurotic system (SMAS). Once an entry pocket is created, the flap is brought through this pocket and placed into the defect. The donor site is either closed primarily as a linear incision or with a secondary bilobed or note flap.

RESULTS

• All repairs yielded satisfactory results with no necrosis, alar notching, or flap loss.
• All repairs had carilage grafts placed underneath the lower edge of the defect in order to provide alar support.
• One patient had a severe reaction to chronic sutures used to close the donor site. Suture abscess incision and drainage as well as postoperative steroid shots were required.
• One patient required a post operative steroid injection for pin cushioning. All patients were satisfied with the functional and aesthetic results.
• Overall symmetry in addition to symmetry of the alar base, tip, and donor site were intact. Color and texture match, including the alar-faceal region, were excellent as well.

REFERENCES