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Tunneled transposition flap for conchal defect



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Key words: concha; Mohs micrographic surgery; reconstruction; skin surgery; transposition flap; tunnel.

SURGICAL CHALLENGE

Mohs micrographic surgery for an infiltrative basal cell carcinoma resulted in a conchal defect with loss of perichondrium. Because of the conchal concavity, the defect can heal by secondary intention. However, this procedure is not suitable for every patient, as healing can be compromised and prolonged.¹ Closure using a skin graft has the risk of graft failure, and because of perichondrium loss, it requires granulation or removal of cartilage. A (myo)cutaneous flap (eg, flip-flop flap) from the posterior side of the auricle is another option, but it requires removal of the cartilage and sets the ear closer to the mastoid.² After discussion of the procedure with our patient, she could not be persuaded to pursue these options.

SOLUTION

We performed a preauricular tunneled transposition flap with a caudal base. We made a subcutaneous tunnel between the tragus and antitragus (Fig 1). The part of the flap through the tunnel was de-epithelialized. The preauricular defect was closed side to side, and the distal part of the flap was sutured into the defect. The 3-month postoperative photographs (Fig 2) demonstrated desirable aesthetic outcome.

This flap has the advantage of a 1-stage procedure with excellent cosmetic outcome. It can be used for all conchal defects, with or without cartilage in situ. There is no need for wound care by the patient, as with secondary intention healing. In our experience, this flap has the advantage over a (myo)cutaneous flip-flop flap, as it does not require removal of cartilage and does not change the position of the ear with respect to the mastoid.

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Drs Marsidi and Genders both performed the surgery and reconstruction, discussed the results, and contributed to the final article.

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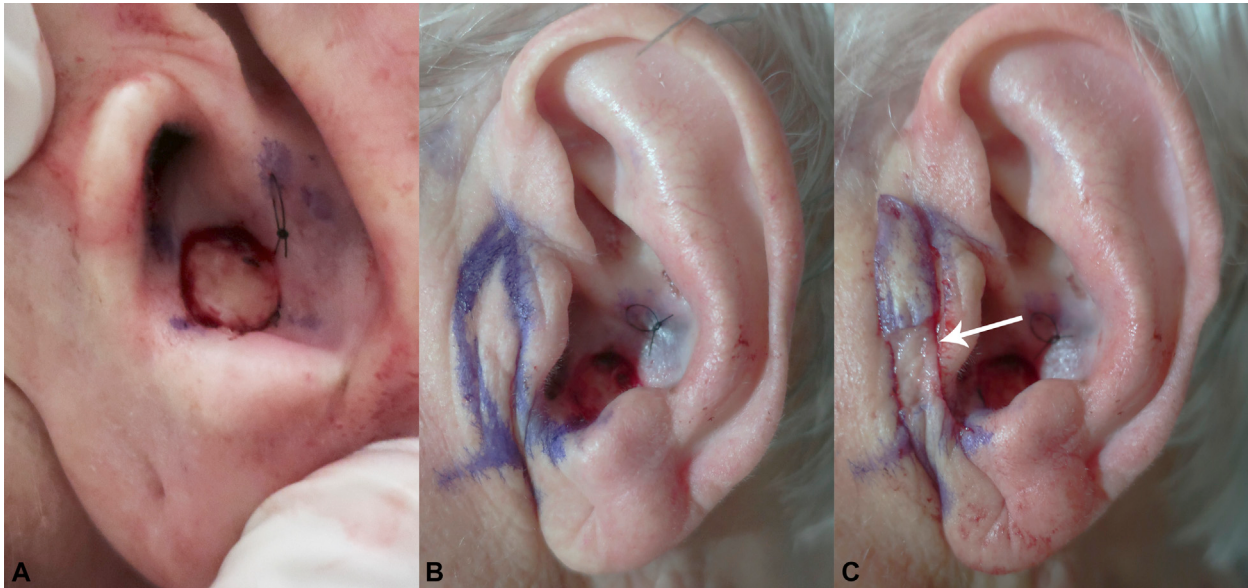


Fig 1. **A**, Mohs micrographic surgery for a basal cell carcinoma resulted in a 10-mm large conchal defect. **B**, Flap design with caudal base. **C**, Flap dissection with a de-epithelialized center (arrow).



Fig 2. **A**, Postoperative reconstruction. **B**, The result after 3 months shows an excellent aesthetic outcome.

REFERENCES

1. Hochwalt PC, Christensen KN, cantwell SR, et al. Comparison of full-thickness skin grafts versus second-intention healing for Mohs defects of the helix. *Dermatol Surg.* 2015;41:69-77.
2. Talmi YP, Horowitz Z, Bedrin L, et al. Auricular reconstruction with a postauricular myocutaneous island flap: flip-flop flap. *Plast Reconstr Surg.* 1996;98:1191-1199.