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RETROSPECTIVE STUDY OF COMPLICATION ON USE OF NASOLABIAL FLAP IN BUCCAL MUCOSA RECONSTRUCTION IN ORAL CAVITY CARCINOMA.

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KEYWORDS :

INTRODUCTION:

- The anatomy of nasolabial region is something of an enigma. The nasolabial fold in this region is absent in the new born and in presence of nerve paralysis. It deepens in old age and retained even in death.
- Cancers of the oral cavity account for 3-4% of all malignancies. In contrast, the figure approaches 10.5% in our country. Buccal mucosal lesions account for 30% of these oral tumors. The high incidence of oral cancers in our country has been attributed to the peculiar social habits.
- The versatility and the usefulness of nasolabial flap is now well recognized in orofacial reconstruction and intraoral use of the nasolabial flap is a simple, fast and reliable procedure and minimizes the morbidity related to speech and swallowing difficulties to a great extent .
- The complication rate of nasolabial flaps is generally low and post-operative results are acceptable even when compared to other distant reconstruction options.

AIMS AND OBJECTIVES:

- It is a retrospective observational study, including the cases that comes to our hospital for a period of five years from 2012 to 2021. We look for outcome of Nasolabial flap used in reconstruction of Carcinoma oral cavity with special emphasis of flap to:
- Maintain Oral competence.
- Facilitate Swallowing.
- Preserving Speech.
- Prevent Aspiration.
- Cosmetic Appearance
- Mouth opening
- Drooling of saliva
- Changes in voice.
- Post operative complication :
- Immediate
- Delayed

MATERIAL AND METHDOS:

- The study included 50 patients of histopathologically proven cases of squamous cell carcinoma of buccal mucosa operated in the ENT department of our hospital between(2012 -2021).

RESULTS:

- In our study Nasolabial flap was used in 50 cases. It is easy to harvest and have good viability.

Post Operative Early Complication In Nasolabial Flap:

EARLY COMPLICATION	HAEMATOMA	OCULAR EDEMA	ERYTHEMA	INFECTION	WOUND DEHISCENCE	SEROMA	DROOLING OF SALIVA	PARTIAL FLAP LOSS	TOTAL FLAP LOSS
50 CASES	3	3	9	7	8	3	15	2	0

Post Operative Late Complication In Nasolabial Flap :

LATE COMPLICATION	TOTAL FLAP LOSS	ORO CUTANEOUS FISTULA	TRISMUS	WHISTLE DEFORMITY
50 CASES	0	0	3	5

DISCUSSION:

- This flap was first described by Sushruta in 600 BC. Many modifications have been made since then. Thiersch was the first to use a transbuccal transfer of this flap for closure of an oral cavity defect. (2)
- The versatility and the usefulness of nasolabial flap is now well recognized in orofacial reconstruction and intraoral use of the nasolabial flap is a simple, fast and reliable procedure and minimizes the morbidity related to speech and swallowing difficulties to great extent (2).
- The nasolabial crease runs from approximately 1 cm superior to the lateral alar rim to approximately 1 cm lateral to the corner of the mouth. Medial to the crease in the region of the corner of the mouth is the orbicularis oris muscle. Superior and lateral to crease is the cheek.(3)
- The skin of nasolabial fold has a superior and inferior blood supply allowing for a superior or inferiorly based flap. The nasolabial flap is a very simple flap used for reconstruction of intraoral defects in the floor of the mouth [4,5], the tongue, cheek, commissures [6], nose tip, nasal ala, and lower eyelids [7]. The facial artery is the arterial supply of the inferiorly based flap. The skin of the nasolabial fold is nourished by the superolabial and alar branches of the facial artery. As the facial artery courses over the dorsum of the nose, it becomes the angular artery. These branches form the distal arterial supply of the inferiorly based flap.(3)
- The infraorbital artery (a branch of ophthalmic artery) and the transverse facial artery (a branch of superficial temporal artery) supply the superolateral skin of the nasolabial region and form the bases of the superiorly based nasolabial flap.(3)
- Buccal and zygomatic branches of facial nerve innervate the muscles surrounding to the nasolabial crease.(3)
- The flap is based on distal branches of the facial artery and its venae comitantes.
- The flap usually designed with an inferior base, but can be based superiorly with a more random vascular supply.
- The design usually places the most medial limit of the flap in nasolabial fold with the superior limit approximating the medial canthus of the eye.
- The medial to lateral dimension of flap is determined by the defect to be reconstructed and the ability to primarily close the donor site. The flap base is situated little below or just above the angle of the mouth. This design allows a flap length of 5-7 cm. With a width of the flap of up to 3 cm, the donor site can be closed primarily without tension. The flap is dissected in a supramuscular plane, keeping the base of the flap as thick as possible. Entrance to the

oral cavity is achieved by dissecting a transbuccal tunnel situated just opposite to the oral defect. Care must be taken not to injure the parotid duct while dissecting the tunnel. Also sufficient width of the tunnel is necessary to avoid constriction of the pedicle. Those parts of the flap pedicle which are placed in the tunnel need careful de-epithelialization.

CONCLUSION:

- Nasolabial flap are undoubtably the workhorse of cheek reconstruction to a large extent unless the defect is too large

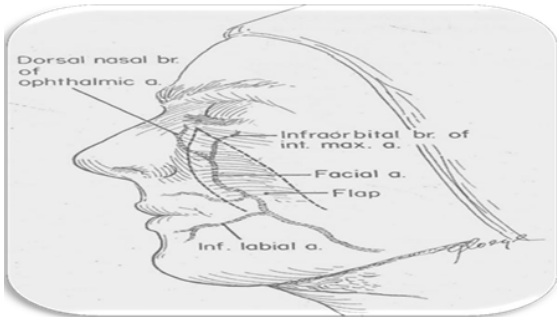

Figure - Anatomy of the Nasolabial Flap Showing Dual Blood Supply

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