Facial Surgical Pearls String From Preop to Postop

BY JANE SALODOF MACNEIL
Southwest Bureau

PARK CITY, UTAH — Facial reconstruction after tumor removal should be guided by the surgical defect rather than presurgical clinical appearance, Dr. Andrew J. Kaufman advised at a symposium sponsored by the American Society of Ophthalmic Plastic and Reconstructive Surgery.

Reconstruction is successful "when the aesthetic and functional goals are met," said Dr. Kaufman, a Mohs surgeon in Thousand Oaks, Calif.

Before proceeding, the surgeon should set functional goals for the patient, said Dr. Kaufman, also of the University of California, Los Angeles. To choose the "correct" repair for meeting those goals, he recommended doing a thorough preoperative evaluation.

This would include consideration of patient characteristics such as age, anxiety level, concurrent medical problems, and type of cancer. Older patients, for example, generally have more loose skin available for repairs.

Other factors to consider beyond size, depth, and location of the wound are whether the function, surface, and structure are intact, Dr. Kaufman said.

The surgeon should determine whether the wound is concave or convex and whether the skin is sebaceous or thin. Concave areas heal well with a graft, and convex areas do better with a flap. Sebaceous skin does not hide a scar as well as thin skin, he said at the meeting, which also was sponsored by the American Society for Dermatologic Surgery and the American Academy of Facial Plastic and Reconstructive Surgery.

Adjacent loose tissue also should be taken into account. "Adjacent tissue is the bank or reserve from which to borrow for repairs," he said, adding that surgeons should "avoid distortion or deviation of free margins and anatomic margins at all costs."

Dr. Kaufman recommended trying to reconstruct within cosmetic units or subunits. "Consider closing multiunit defects in individual defects," he said, suggesting that incision lines be placed at junctions between units/subunits or rhytids/furrows.

When it is appropriate, the wound should be allowed to heal by secondary intention. For big defects, consider three options: secondary intention, graft, or making the defect smaller (closing it in subunits or using combination repairs).

'Don't get in over your head.' If you're uncomfortable with a reconstruction, refer it to another surgeon.

DR. KAUFMAN

Consider all options for repair. "A lot of time people get locked into an idea," he said, warning that the first choice may not be the best. Assess what is missing and where its replacement is going to come from. "Look to see: Where is the loose skin, and where are the relaxed skin tension lines?" said Dr. Kaufman.

"Don't get in over your head," he cautioned. Each surgeon should build on experience, starting with complex repairs, going on to small flaps and grafts, and later attempting more advanced flaps. If uncomfortable with a reconstruction, refer it to another surgeon.

He went on to offer the following advice:

- Distorting an anatomic landmark is worse than having a longer scar.
- Keeping incision lines between cosmetic units or subunits wherever possible will help, he said, "to hide scar in shadows caused by concavities and convexities."
- Flaps usually are better than grafts for matching color, texture, and thickness, but grafts "work well in thin, shiny skin and in reconstruction of complete units or subunits," he noted.
- When doing a repair, always make sure the margins are clean before starting.

Surgeons can enhance patients' experience by playing classical music, sending them home with wound supplies, and calling to see how they are recovering. "Patients love it. They don't expect doctors to call them at home," he said. "By doing those kinds of things, you put in their mind that they are going to have good results." ■