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RECONSTRUCTION OF THE LOWER LIP WITH TWO FLAPS FROM THE UPPER LIP HINGED ON THE SUPERIOR LABIAL VESSELS

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In 1848, Stein described a method of reconstructing the lower lip with 2 flaps from the centre of the upper lip hinged on the labial vessels (Fig. 1). This method however badly deforms the philtrum. Estlander (1877) described a lateral flap from the upper lip but this tends to divide the commissure and lead to dribbling of saliva. Kazanjian and Roopenien (1954) described a modification of Stein's operation in which the 2 flaps were taken from each side of the philtrum (Fig. 2); it is useful in smaller defects of the lower lip. For larger defects, *i.e.* up to 80 per cent of the lower lip, the modification of Wexter and Dingman (1975) gives satisfactory results (Fig. 3). Both commissures and the philtrum are preserved. I have used this technique in a number of cases and present 2 to illustrate the method and the results.

Case 1. This 60-year-old man had a large squamous cell carcinoma of the lower lip. It was widely excised and skin was stitched to mucosa around the defect. Histology confirmed total excision of the tumour, there were no palpable lymph nodes and reconstruction of the lower lip was undertaken 3 months after the excision. The left lower lip stump measured 1 cm while the right stump measured 0·5 cm; the upper lip at rest was 7 cm long. Two large flaps as shown based laterally on the labial vessels were turned down into the defect. The pedicles were divided and inset 3 weeks later (Figs. 4 and 5).

Case 2. A similar case is shown in Figure 6. After excision of the cancer, a 3-month period elapsed before the defect was reconstructed by 2 flaps from the upper lip. The stumps of the lower lip measured 1 cm and 0·3 cm while the upper lip at rest measured 9 cm. The flaps from the upper lip were 2·2 cm long and their pedicles were divided after 3 weeks.

DISCUSSION

Many ways of reconstructing the lower lip are to be found in any textbook of plastic surgery. This does not necessarily mean that none is good but rather that different shapes and sizes of defects and different patients need different techniques.

The advantages of the technique presented are:

The commissures are preserved;
Good movement in both lips is retained;
The opening of the mouth is adequate to insert dentures;
The cosmetic results are good.

There are also some disadvantages: 2 operative stages are required and in the interval of about 3 weeks between these the mouth is almost closed. The initial numbness in the middle of the lower lip gradually recovers.

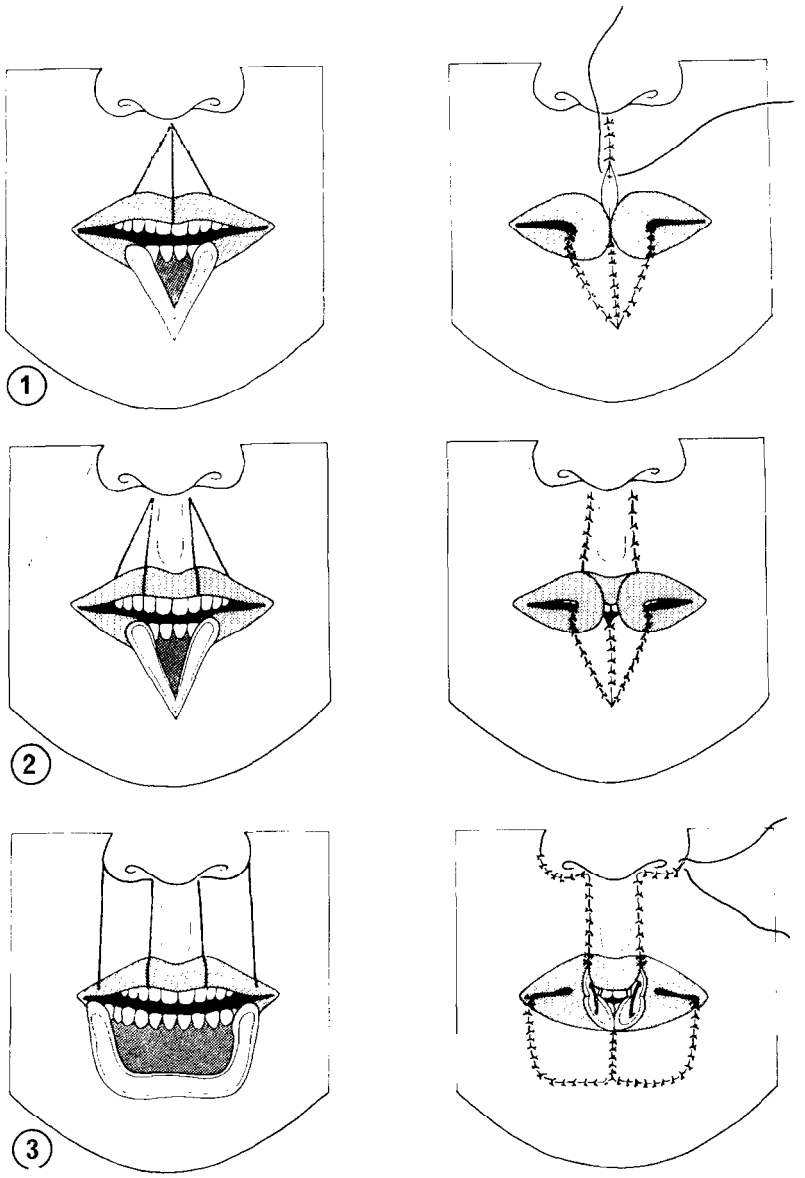

FIG. 1. The procedure of Stein (1848). It caused severe deformation of the philtrum.

FIG. 2. The flaps of Kazanjian and Roopenian (1954) leave the philtrum intact and are useful for smaller lower lip defects.

FIG. 3. For larger defects rectangular flaps are required (Wexler and Dingman, 1975).

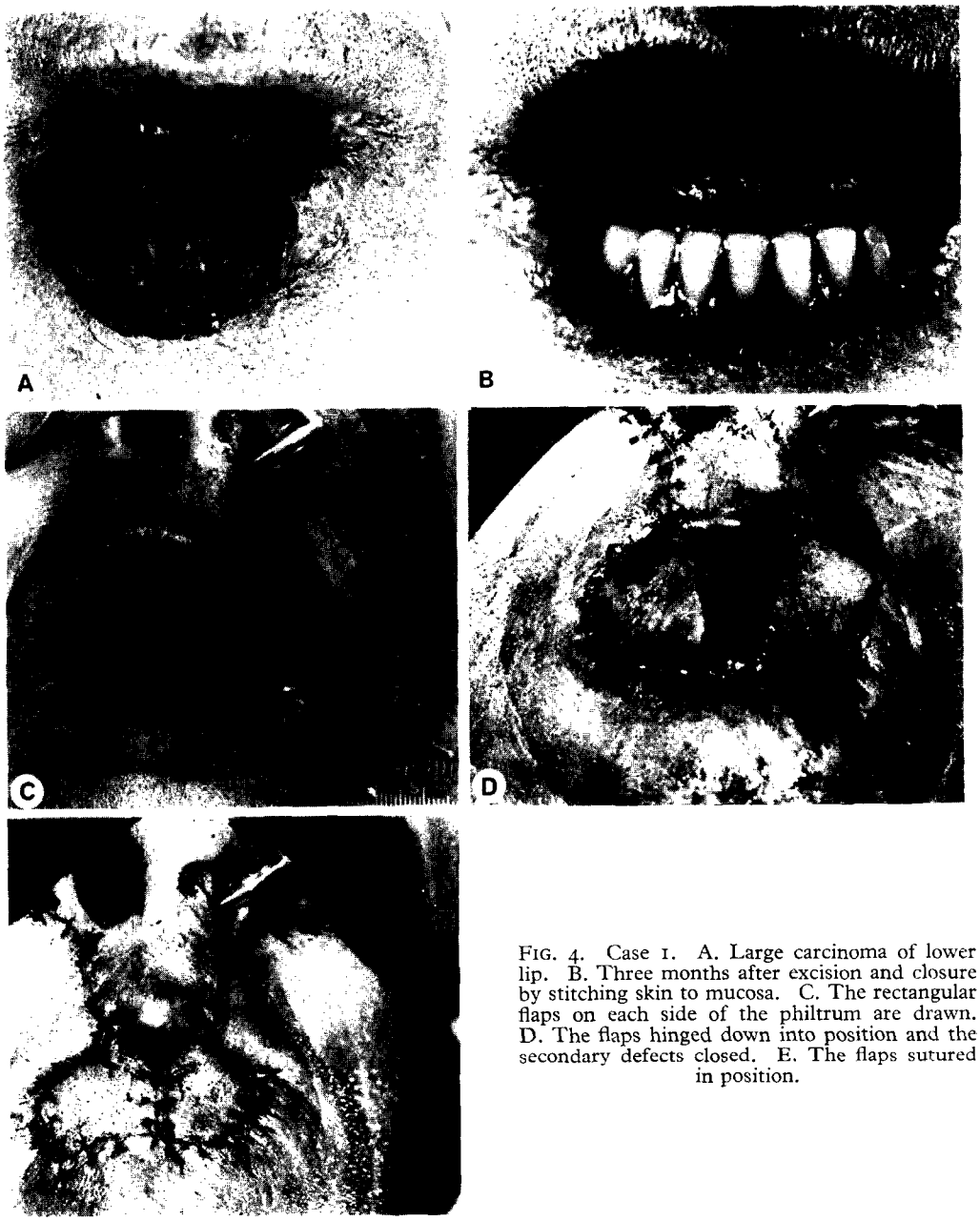

FIG. 4. Case 1. A. Large carcinoma of lower lip. B. Three months after excision and closure by stitching skin to mucosa. C. The rectangular flaps on each side of the philtrum are drawn. D. The flaps hinged down into position and the secondary defects closed. E. The flaps sutured in position.

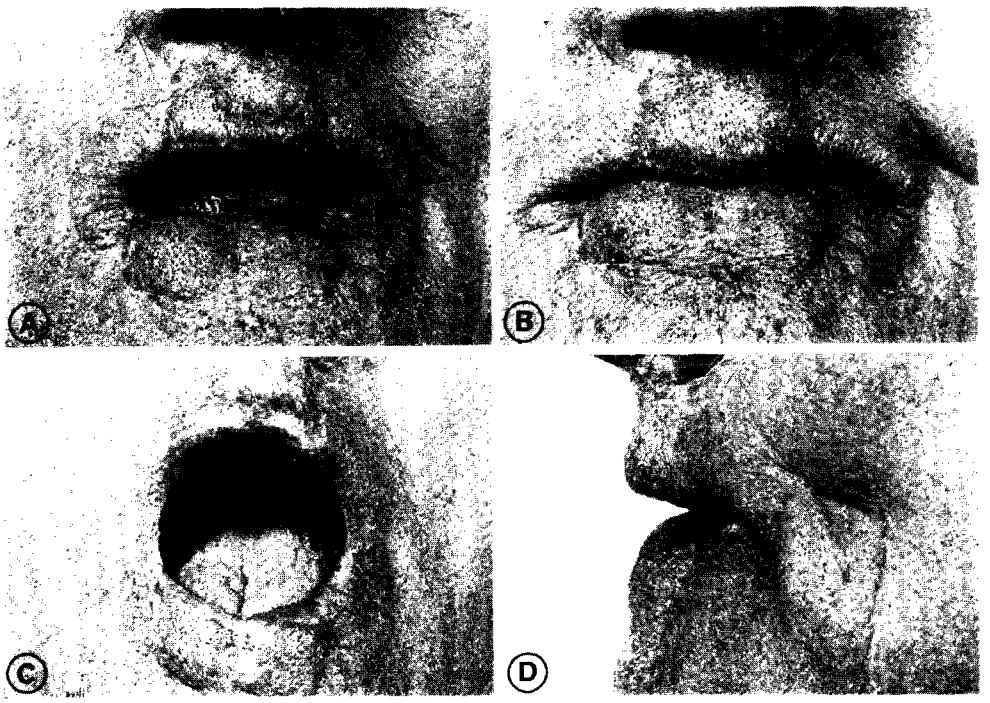

FIG. 5. Case 1. A to D. Five months after operation with the patient wearing dentures.

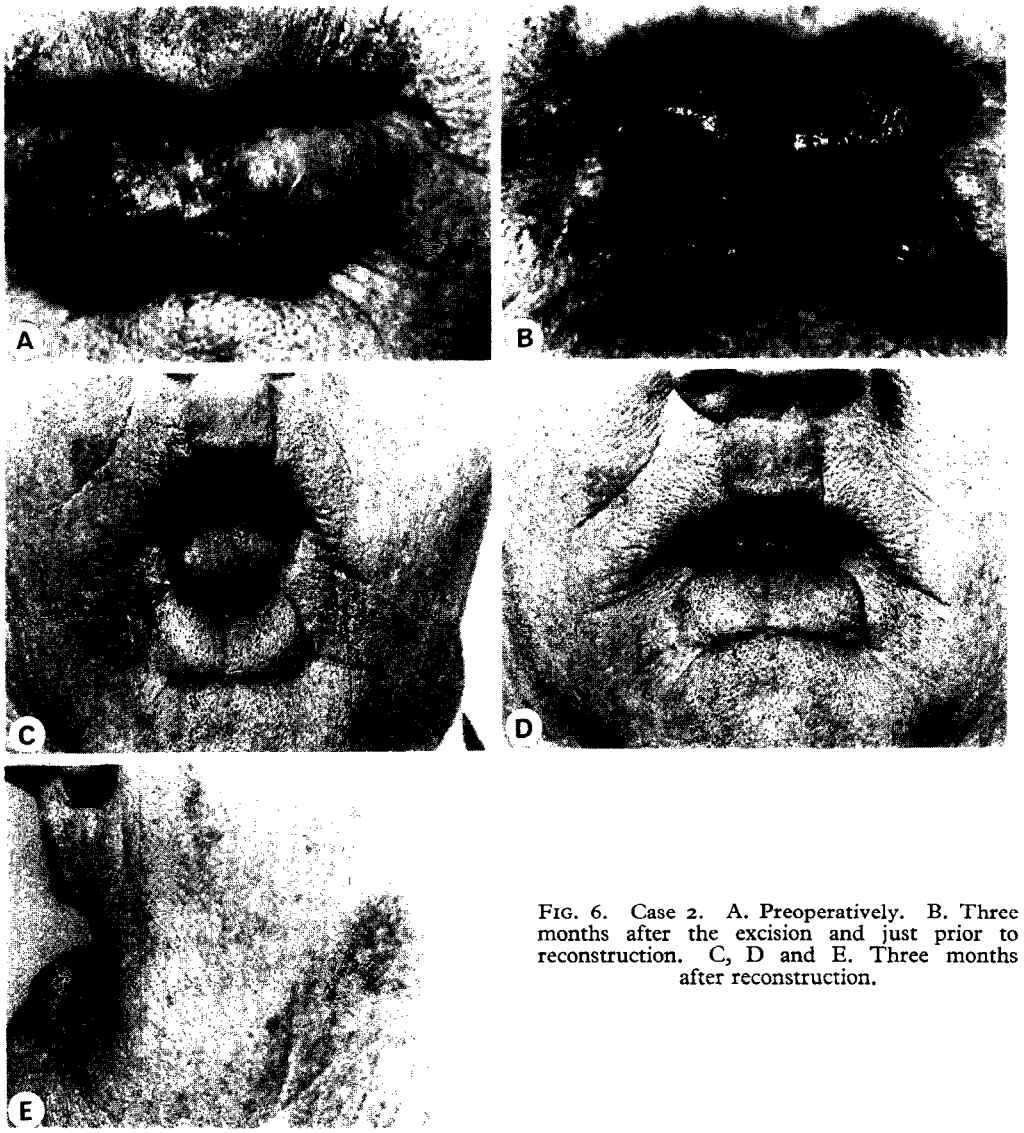

FIG. 6. Case 2. A. Preoperatively. B. Three months after the excision and just prior to reconstruction. C, D and E. Three months after reconstruction.

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