

Can We Add Auricular Composite Graft to Our Armamentarium for Alar Rim Reconstruction?

Ali Manafi^{1*}, Amir Eslami Shahr Babaki²

1. Department of Plastic Surgery, Tehran University of Medical Sciences, Tehran, Iran;
2. Sport Medicine Research Center, Tehran University of Medical Sciences, Tehran, Iran

ABSTRACT

BACKGROUND

The ala of the nose, with its particular texture and characteristics, poses both aesthetically and functionally intriguing, and is rather problematic regarding choices for reconstructive methods. Both flaps and grafts have been used to restore natural structure of nasal ala. The present study summarizes a ten-year period of reconstructive surgery, using skin/dense subcutaneous tissue/skin grafts, with a mean of 4 years and 8 month-follow-up.

METHODS

Cumulatively 56 patients were reported. Some of them required surgery due to previous cosmetic rhinoplasty. In 47 of the cases, a small graft from the non-cartilage bearing junction of ear lobule to helical rim sufficed, but 9 patients had rather large defects, for which grafts were harvested from the helical root. Donor sites were primarily closed, and grafts were implanted in place in a single, rapid surgery.

RESULTS

All small grafts had excellent take. Of 9 large grafts, 5 had excellent, three had acceptable, and one, in a male smoker, had a failure to take. During follow-up, no gross deformity or scar was detected in either donor or recipient site.

CONCLUSIONS

We have demonstrated that using auricular skin/dense subcutaneous tissue/skin composite grafts has favorable long term results for reconstruction of alar rim deformities in both large and small grafts. However, its advantages lean more towards small grafts and applicability of large grafts requires further studies.

KEYWORDS

Auricular composite; Graft; Armamentarium; Alar rim; Reconstruction

*Corresponding Author:

Ali Manafi, MD,
Department of Plastic Surgery,
Tehran University of Medical Sciences,
Samsung Building, 3rd floor, Suite
305, Vanak Square,
Tehran, Iran.

Tel: +982188879942

Fax: +982188879941

E-mail: dramanafi@yahoo.com

Received: July 14, 2012

Accepted: October 3, 2012

Please cite this paper as:

Manafi A, Eslami Shahr Babaki A. Can We Add Auricular Composite Graft to Our Armamentarium for Alar Rim Reconstruction? World J Plast Surg 2013;2(1): 35-41.

INTRODUCTION

The alar rims are fragile and complex structures. Their unique size, height, thickness and symmetry form the natural nasal appearance and function. The specialized skin which supports

and supplies these complex structures provides competence of the external nasal valves and patency of the inlets to the nasal airways.¹⁻³ The most common causes of alar rim distortion include trauma, congenital malformations, anatomical variations such as alar cartilage malposition,⁴ surgical interventions and cosmetic rhinoplasty. All these factors might alter the symmetry and contour of alar rims and prevent their ability to function as external valve stabilizers.⁴

Skin replacement⁵ and cartilage or bone grafts⁶⁻⁹ have been used successfully for reconstructive operations in many instances. However, as the alar rims provide both skin cover and external valvular support, it is needed to preserve both functions. Therefore, autologous grafts that simultaneously replace both the cutaneous and cartilage deficiencies are often required if replacing the alar rim is needed. Composite skin/cartilage grafts and skin/dense subcutaneous tissue/skin grafts harvested from the ear provide the ideal material for such reconstructive surgeries. Patients with abnormality of alar rims or excessive alar base resection are challenging cases to reconstruct.

We present a decade-long experience with composite grafts, consisting of skin/dense subcutaneous tissue/skin form non-cartilage bearing pinea between helical rim and lobule of the auricle, to restore the normal appearance and function of the alar rim.

MATERIALS AND METHODS

Between 2001 and 2011, 56 patients with alar rim malformation were recruited in this prospective case series study. The major causes of alar rim malformation in the study population were trauma and iatrogenic causes, that is, small and stenotic nostrils due to alar base resection during previous rhinoplasty. Mean length of follow-up was 4 years and 8 months, with a maximum of ten years in some cases.

All reconstructive procedures were performed in open approach. In 47 patients who had undergone previous rhinoplasty and needed small grafts, in conjunction with secondary rhinoplasty techniques for reconstruction of the whole nasal deformity, composite graft was harvested from the junction of lobule to helix in a wedge shape, as shown in Figure 1.

Figure 1

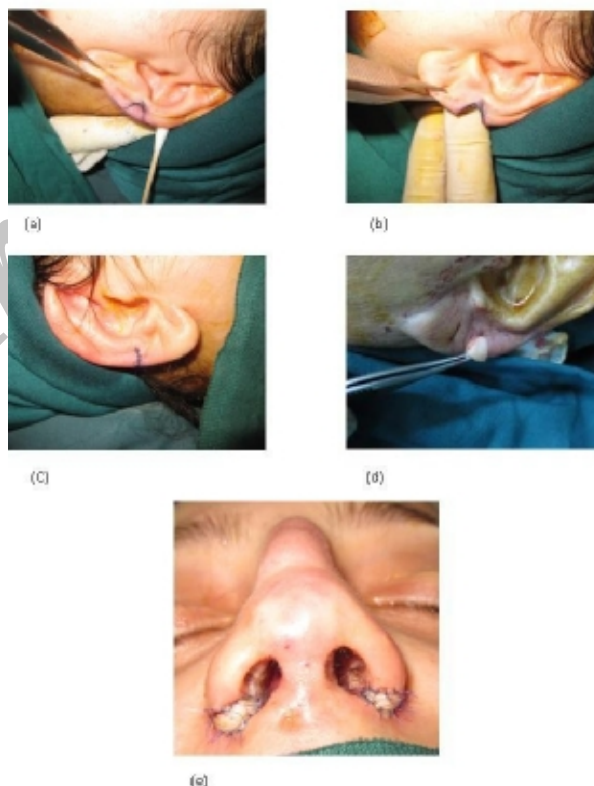


Fig. 1: (a) A piece with suitable size, at the junction of helix and lobule, is marked, (b) and harvested, (c) donor site closed primarily, (d) the composite graft, (e) is placed at the incised alar rim defect, ergo normal appearing nostrils.

As demonstrated, the site of previous incision in alar base was incised with a Number 15 blade, as required (Figure 1-a). Graft was then placed in position and sutured to the recipient site (Figure 1-e). The donor site was primarily closed. We tried to make alar structure and shape more normal looking, both aesthetically and functionally. In the remaining 9 patients, a large graft was required and the composite grafts were harvested from the helical root. The composite grafts were implanted in either the alar rim defect or in the site of previous extensive alar rim resection, as well as the missing part of the alae.

RESULTS

Fifty six patients with mean age of 22 years (range between 17 and 62 years) made up our study population. All of small grafts had excellent take and satisfying appearance for patients, without obvious deformity of donor site.

Five of large grafts had excellent take, 3 of them had acceptable take and one case had failure to take. The pre-operative and post-operation pictures of four patients were illustrated in Figures 2-5.

DISCUSSION

The ala is an important component of nasal anatomy, both aesthetically and functionally. A careful assessment of the defects should be undertaken to determine the extent of lost skin cover and skeletal structure. Taking these factors into account may help to re-establish the anatomy and function of these structures as well as to support the reconstruction against the forces of fibrosis and contracture.

Composite grafts are composed of full thickness skin and surrounding periosteum and cartilage or skin/dense subcutaneous tissue/skin.¹⁰⁻¹² Composite graft from either the helical rim or the root has been recommended



Fig. 2: A patient with facial burn scars, with a defect at the right alar margin, on profile view, (a) before and (b) after reconstruction with composite graft and z-plasties. Images (c) and (d) are three-quarters view of the same patient demonstrating acceptable take and appearance.



Fig. 3: A lady who complained of asymmetric nostrils and other deformities following rhinoplasty. Images (a) and (b) show her on frontal view, before and after tertiary rhinoplasty and surgical correction with small composite grafts on the right alar rim, respectively. Figures (c) and (d) are of the same individual, on three-quarters view. Figure (e) shows a close-up view of the same individual 10 days after surgery. The site of graft is indicated by an arrow. Figures (f) and (g) are from basal view.

for reconstruction of alar rim defects.¹³ Sangavi presented a case report of a 16 years old girl with isolated congenital alar defect who underwent reconstruction with auricular composite graft. Composite auricular graft resulted in an excellent nasal contour correction without healing abnormality or any obvious deformity in the donor site.¹² Coban and his colleague used the root of helix as the composite graft donor site for reconstruction of post-burn alar rim deficiency.¹⁴ Constantian used auricular composite graft reconstruction in 100 secondary and tertiary rhinoplasty patients.¹⁵ In their series, 99% of the grafts survived in their

entirety and only two patients had partial unilateral graft loss. Moreover, Klinger *et al.* reported reconstruction of a full-thickness alar wound in a 20 year-old man using an auricular conchal composite graft¹⁶ which resulted in a complete repair of the defect with excellent wound healing as well as good functional and aesthetic results.

However, the basis of treatment in these cases is resection of scar tissue or deformed ala, then grafting a piece of tissue in a 3-dimensional shape similar to normal anatomy, to the alar area defect. These procedures are complicated and time-consuming, require a



Fig. 4: A lady presenting with asymmetry in nostrils in addition to dissatisfaction with previous rhinoplasty and face-lift, (a) before, and (b) after secondary rhinoplasty, reconstruction with a small composite graft, face-lift and lipoplasty, on frontal view. Additional images show frontal views of her, when presenting for the first time (c), after secondary rhinoplasty and face-lift (d), and three months after lipoplasty and performing a composite graft on the right ala (e). Images (f), (g) and (h) show the same individual on profile view.

great deal of expertise, and it is not always feasible to harvest tissue with these characteristics. Moreover, there are the problems of failure to take and healing abnormalities at the donor as well as recipient site.

In the present series of 56 patients, we evaluated long term results of composite graft take in patients undergoing alar rim reconstruction. Our results demonstrated that composite graft had favorable results in alar rim

reconstruction. In the present study, we utilized two different sets of grafts.

For small defects or for individuals with congenital or acquired nostril stricture, a small wedge-shaped part of (non-cartilage bearing) helicolobular junction, consisting of dense subcutaneous tissue in the middle and skin on both sides, was used. This composite graft had an excellent take in all 47 patients who needed small grafts. Due to limited manipulation,



Fig. 5: A young lady who had undergone two previous rhinoplasties, and the surgical and unnatural appearance of nasal tip and nostrils was her main complaint. Images (a) and (b) show her after tertiary rhinoplasty and composite grafting, on both sides, on frontal view. Figures (c) and (d) show her on basal view.

injury of donor site was very limited and no gross deformity or scar was observed in any of these patients.

The other graft was harvested from the helix root. It was similar to the more traditional composite grafts in that it contained cartilaginous tissue. These grafts were needed to reconstruct alar rim in 9 patients who had relatively larger defects. We observed that in 5 cases the grafts had excellent take. In 3 individuals, the grafts had acceptable take, but in one patient, who was a male smoker, the graft failed to take.

It has been suggested by other authors that auricular composite graft used for reconstruction of the alar rim should not be larger than 1.5 to 2 centimeters in diameter¹⁷ to ensure reliable revascularization. This supports our

results which showed that in 9 patients who needed large composite grafts, only 5 patients had excellent graft take. However, all of 47 patients with small grafts had excellent graft take.

The main advantage of composite graft is that it can be performed in a single, fast operation with excellent contour correction.¹² The main disadvantage of composite graft is that its use for large defects (larger than 2 centimeters) has not been recommended, and other therapeutic modalities such as nasolabial or forehead flap can be performed for these defects. Moreover, the final color of composite graft may not be very satisfying.¹²

In conclusion, our results demonstrated that using auricular non-cartilage bearing composite grafts has favorable long term results in reconstruction of alar rim deformities.

Although this was true for both large and small grafts, it seems that further studies are needed to clarify the advantages of this procedure in large grafts.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

REFERENCES

- 1 Robinson JK, Burget, GC. Nasal valve malfunction resulting from resection of cancer. *Arch. Otolaryngol. Head Neck Surg* 1990;**116**:1419-24.
- 2 Constantian MB. The incompetent external nasal valve: Pathophysiology and treatment in primary and secondary rhinoplasty. *Plast Reconstr Surg* 1994;**93**:919-31.
- 3 Sheen JH, Sheen AP. *Aesthetic Rhinoplasty*, 2nd Ed. St. Louis: Mosby, 1987; pp. 106-110.
- 4 Sheen JH, Sheen AP. *Aesthetic Rhinoplasty*, 2nd Ed. St. Louis: Mosby, 1987; pp. 988-1011.
- 5 Dupertuis, SM. Free ear lobe grafts of skin and fat. *Plast Reconstr Surg* 1945;**1**:135-44.
- 6 Brown JB, Cannon B. Composite free grafts of skin and cartilage from the ear. *Surg Gynecol Obstet* 1946;**82**:253-5.
- 7 Sheen JH, Sheen AP. *Aesthetic Rhinoplasty*, 2nd Ed. St. Louis: Mosby, 1987; pp. 372-382.
- 8 Sheen JH, Sheen AP. *Aesthetic Rhinoplasty*, 2nd Ed. St. Louis: Mosby, 1987; pp. 474-505.
- 9 Gunter JP, Rohrich, R. Correction of the pinched nasal tip with alar spreader grafts. *Plast Reconstr Surg* 1992;**90**:821-9.
- 10 Stucker FJ, Shaw GA. Perichondrial cutaneous graft, a twelve year clinical experience. *Arch. Otolaryngol. Head Neck Surg* 1992;**18**:287-292.
- 11 Rohrer TE, Dzubow LM. Conchal bowl skin grafting in nasal tip reconstruction: Clinical and histologic evaluation. *J Am Acad Dermatol* 1995;**33**:476-481.
- 12 Sangavi BA. Congenital Alar Defect, Reconstruction with Auricular Composite Graft. *Am J Med Sci* 2012;**5**:205-208
- 13 Sood VP. *Corrective Rhinoplasty* 1st ed. [City], CBS Publishers and Distributors, [Year]; pp. 158-9.
- 14 Coban YK, Geyik Y. An ideal composite graft donor site for postburn alar rim deficiencies: root of helix. *J Craniofac Surg* 2010;**21**:1246.
- 15 Constantian MB. Indications and use of composite grafts in 100 consecutive secondary and tertiary rhinoplasty patients: introduction of the axial orientation. *Plast Reconstr Surg* 2002;**110**:1116-33.
- 16 Klinger M, Maione L, Villani F, Caviggioli F, Forcellini D, Klinger F. Reconstruction of a full-thickness alar wound using an auricular conchal composite graft. *Can J Plast Surg* 2010;**18**:149-51.
- 17 Soni A. Single stage reconstruction of alar rim defect using auricular composite graft: a case report. *Indian J Plast Surg* 2005;**38**:50-153.