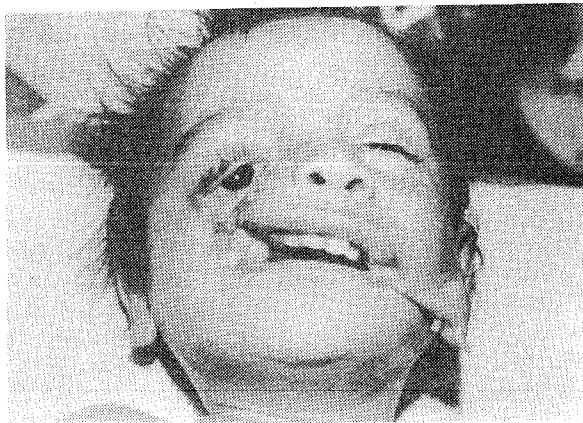


Letters to the Editor

A RARE CONGENITAL ANOMALY OF THE FACE.

Sir,

We had the opportunity to treat a 2 years old child with a rare combination of congenital anomalies of the face (Fig 1). The child had a facial cleft on the right side of the face and an abnormal swelling on the left side over the region of the parotid gland with a cord like structure starting from the swelling and entering the oral cavity.



(Fig-1) Photograph showing facial cleft No.5 on the right side and an abnormal parotid gland and duct on the left side of the face.

The right side cleft extended from the upper lip just medial to the angle of the mouth to the right lower lid corresponding to cleft No.5 of Tessier. On the left side there was a soft tissue swelling situated over the left parotid region. It was attached to an elongated cord like structure which passed around the left angle of the mouth and ended in the cheek by the side of the left upper alveolus. The structure ended at the site of the opening of the parotid duct. The whole length of the structure was totally separated from the skin of the cheek and also from the mucosa. Initial treatment offered to the child was the repair of the facial cleft by soft tissue correction. On the left side, the whole swelling along with the structure was excised. It was sent for histopathological examination which

revealed aplastic parotid tissue in the swelling and the elongated structure was non-canalised.

Cleft No.5 of Tessier is a rare anomaly. The cleft is positioned just medial to the corner of mouth. The cleft courses cephalad across the lateral portion of the cheek into the area of the middle and lateral thirds of the lower eyelid. On the left side, the whole structure was found to be under developed parotid gland and duct, but they were lying outside. This case is presented for the rare occurrence of this combination.

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A SIMPLE METHOD TO CHOOSE THE RIGHT LIMBERG FLAP

Sir,

For a defect which can be closed by a Limberg flap, four possible flap options could exist. Though the technique is not new, herewith I would like to discuss the series of steps which has consistently helped me to choose the best suitable plan for the benefit of the trainees.

Step I : Decide the area of maximum availability of skin around the lesion by pinching up the skin. The secondary defect has to be in an area where tissue is available for primary closure. On the face it is usually parallel to crease lines - Area of Maximum Skin Availability : AMSA.

Step II : Draw a line passing through the centre of AMSA or through the creaseline towards the centre of lesion - Line of Maximum Skin Availability : LMSA (Fig.1).

Step III : Do a rhomboid excision of lesion in such a way that 120 deg. angles are bisected by LMSA i.e. 2 equilateral triangles are formed on either side of LMSA (Fig.2).

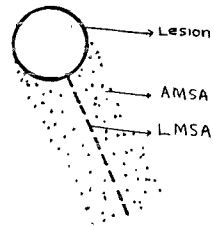


Fig-1

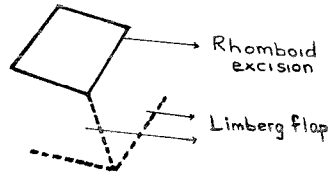


Fig-2

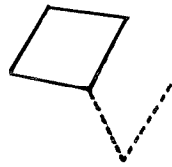


Fig-3

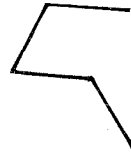


Fig-4

Step IV : A point is marked on LMSA so that its length is the same as that of short diagonal of rhomboid. 2 Flaps are possible by extending this point parallel to the side of defect for the same distance. Out of these two flaps one flap is chosen which causes least anatomical distortions.

The final scar can be drawn easily : Draw the 3 sides of defect excluding the side from which the flap is taken. Extend this line along LMSA for a

distance equal to the length of short diagonal (Figs 3 & 4).

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Reference

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