

Case Series

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Nasal reconstruction in darker skin: is the subunit principle valid?

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ABSTRACT

The subunit principle of aesthetic nasal reconstruction is well known among reconstructive surgeons and it is considered to be the excellence of care. It advocates to reconstruct a nasal defect as per the specific subunit, placing the suture line at a border of one subunit and its adjacent within the nasal surface. Individuals with skin types III to V are prone to hyperpigmentation, hypertrophic scars, keloids and obvious suture marks. Applying the subunit principle in these darker complexion patients would not be sufficient. In fact, it would result in a scarred nose with a patch. With our frequent experience in such cases, it was very important to revisit the mentioned principle. In darker complexion individuals requiring significant part of their nose to be reconstructed, a consideration should be given to entire nasal unit reconstruction. This would allow placing the seams at junction with adjacent regions (cheek and lip) rather than within the nose and much acceptable aesthetic outcome.

Keywords: Facial, Nasal, Aesthetic, Skin, Dark, Complexion

INTRODUCTION

The expression aesthetic reconstruction refers to restoration post disease or trauma process to near normal appearance.

It is Gonzalez-Ulloa who first described “ridges and valleys” or slightly convex or concave surfaces on the face. They explained these terrains are determined according to underlying hard and soft tissues.¹

Major units are the forehead; upper-lower eyelid, nose, cheek, upper-lower lip, chin, sub-mentum and the neck (Figure 1).

Gonzalez then named those into “facial aesthetic regions or units” and were the first who applied the surgical principle of discarding peripheral healthy skin in order to restore it a unit. They advocated reconstructing the entire nose or forehead, and considered a uniform sheet of a skin flap or even a graft.²

Millard described aesthetic restoration of major nasal defects using the Indian forehead flap and demonstrated it by making templates of the defect and the main units as thirds.³

The principle of aesthetic “nasal subunit” reconstruction by Burget and Menick is well respected and considered to be the excellence of care in nasal reconstruction.⁴ They have recognized nine “subunits” defined also by gentle valleys and low ridges that become apparent with light and shadows. Three are unpaired; dorsum, tip and columella. Other three are paired; side walls, alar-nostril sill and the soft triangles (Figure 2).

They used strategy of Gonzalez and applied it specifically on nasal surface: simply whenever 50% of a subunit as an example the dorsum or soft triangle etc., is affected then the defect should be extended slightly to involve a regular subunit shape, which is then reconstructed using a flap or full thickness skin graft (FTSG).

Supposedly this would maximize camouflage of the transferred tissue and the scar. Those major three contributions (Gonzalez followed by Millard J and then Burget-Menick) converted the nasal reconstruction into a truly artistic procedure. The subunit principle of Burget and Menick was often referred as the (rule of 50%).



Figure 1: Illustration of facial units based on the original ideas of Gonzalez et al.¹

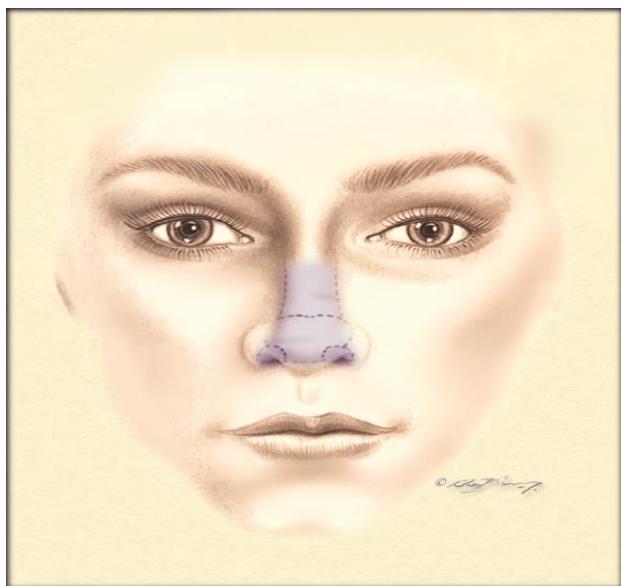


Figure 2: Illustration of nasal aesthetic subunits based on G. Burget and F. Menick's principles in 1985.

CASE SERIES

Case 1

The patient shown in Figure 3 who has type IV skin presented for a second opinion, he had a history of

traumatic skin loss and a postauricular FTSG two years ago. The graft is quite hyperpigmented, has distinct borders and very obvious.

Generally speaking, as per classic teaching, it is well known that dorsal subunit (by Burget/Menick) is one of the nasal areas that are quite encouraging and acceptable to use a FTSG.⁴

Case 2

The patient shown in Figure 4, had a history of MVA few years back and presented with this picture of hypertrophic scar over the nasal tip region. Such a complication is also quite unusual for type I and II skin patients.



Figure 3: Case 1 type IV skin adult, 2 years post FTSG to dorsal nasal subunit following trauma. Patient came for a second opinion, the graft is hyperpigmented and very obvious.



Figure 4: Case 2 skin type-III skin adult, few years post trauma with hypertrophic scars on nasal tip, dorsum and columella.

Type III skin patients is a dominant type in many parts of the world, individuals with skin types ranging from to III

to V are prone to scar hyperpigmentation, obvious stitch marks, hypertrophic scars and keloids. This is true regardless of the geographical differences.^{5,6} The outcome shown in the above patients is however not by any means one would expect and or accept to see in an average Caucasian type I or type II skin, if they had same scenario.

Case 3

On the other extreme and compared to the above cases, a patient is shown in Figure 5 with BCC on the nasal tip region, which is an area that many would advocate for a flap due to the thick oily nature of skin here as well it is more adherent to underlying cartilage. However, this (type I skin) patient was only treated with simple excision, a FTSG and without applying the 50% rule. The graft is barely noticeable apart from slight hypopigmentation. The obvious explanation is the fair skin type.



Figure 5: Case 3 skin type 1 adult with superficial BCC to nasal tip subunit, (a) post FTSG following localized excision without utilizing subunit principle, with barely noticeable scar, apart from slight graft hypopigmentation and (b) Courtesy of Dr. M. F. Stranc.

Case 4

The patient shown in Figures 6-9 had a skin type-V, with history of facial infection as a neonate complicated with significant nasal tissue loss. As a young adult, patient wanted the best possible outcome. A consideration of restoring his overall nasal skin with a scalping flap as one big unit was given, avoiding any suture lines between the subunits otherwise.⁷

If the nasal lobule or tip region was built as separate subunits the way normally one would with standard paramedian forehead flap utilizing Burget and Menick principles, this patient would have had obvious hyperpigmented scars all over his nose.



Figure 6: Case 4 skin type V 19 years old, with history of neonatal facial infection, (a) nasal soft tissue loss and atrophy. Then 10 years post reconstruction of whole nasal unit with scalping flap (and a cantilever bone graft), in order to keep suture lines at nasal-facial groove; has undergone orthognathic surgery as well; and (b) patient is been given option of tissue expansion to replace the skin grafted area on forehead donor site, but he did not seem to be concerned.



Figure 7: Case 4 intra-operative. Cantilever iliac crest bone graft held to radix with mini-plate and screws. Most of external nasal skin has been discarded.



Figure 8: Nasal coverage with scalping flap, profile view.



Figure 9: Same patient, in setting of the scalping flap. Approximately 7cm width of unilateral forehead is used in order to accommodate the neo nose basal view.

Case 5

The patient in Figure 10 is a 75 years old type IV skin with SCC, who was also considered for total nasal reconstruction and coverage with scaping flap.



Figure 10: (a) Type IV skin, 75 years old with advanced SCC and significant nasal defect. Three months post total nasal reconstruction and coverage with a scalping flap and (b) edema is still noticeable.

DISCUSSION

In the oriental patient nasal reconstruction, who are known of their increased risk for abnormal scarring, Hasio et al has proposed a modification to the original guidelines by Burget and Menick. They consider discarding extra healthy skin adjacent to subunit, for a better conceal to scars.⁸

The overall experience and literature are deficient in nasal reconstruction for types IV and V skin patients, due to the probable reason of less photosensitivity and incidence of skin cancer. Defects due to other reasons are not uncommon but unfortunately still there is not much written.

Singh et al have looked at their experience in (Caucasian patients) where the subunit principle was violated in 31% of their patients. They looked at multiple factors including practicality, and questioned whether there is even a need for Burget and Menick's rule of 50%. The cases where the 50% rule was violated (in type I and II patients as per photos), most of them had local flaps with incisions traversing in the middle of subunits. Even though as per their evaluation tool, they had excellent results in 85% of those patients.⁹

In day to day practice, close to fifty percent of surgeons in North America once indicated they are not following the subunit rule, simply because they felt they can get good results any ways.¹⁰

This provides enough evidence, in general skin types I and II heal with minimum scarring and pigmentation issues, and their scars are forgiving. With dark patients the situation is exactly the opposite.

The subunit principle for nasal reconstruction is suitable mostly for the fair complexion patients. In a dark patient, using such a principle would probably result in a quite undesirable appearance, the abnormal scarring process would not respect any subunits or borders.

This is the reason we do not believe the rule of 50% by Burget and Menick is by any means valid or adequate for the dark patient. Such a principle is to be respected but it does have its exceptions.

CONCLUSION

The original concept by Gonzalez-Ulloa of replacing the entire region or main unit probably suits better the dark complexion patients, as shown above.

In fact, the whole practice of plastic surgery becomes quite different when dealing with types IV and V patients on frequent basis. Unfortunately, the literature has been deficient from this aspect. In terms of nasal reconstruction, it is unfair for the darker complexion

patients to be treated with a general rule made for the fair complexion patients, without considering skin types.

In saying so, we are not advocating that even for minimal defects to generalize a major reconstruction such as scalping flap or extended forehead flaps in the dark patients. However, surgeon and the patient have to be aware of what to expect, and be able to explore wider options.

It should also be kept in mind; regardless of socioeconomic status, geographical, ethnic or even age differences, all patients coming to reconstructive plastic surgery, have high expectations.

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