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Lip Reconstruction

Gerard J Bayley

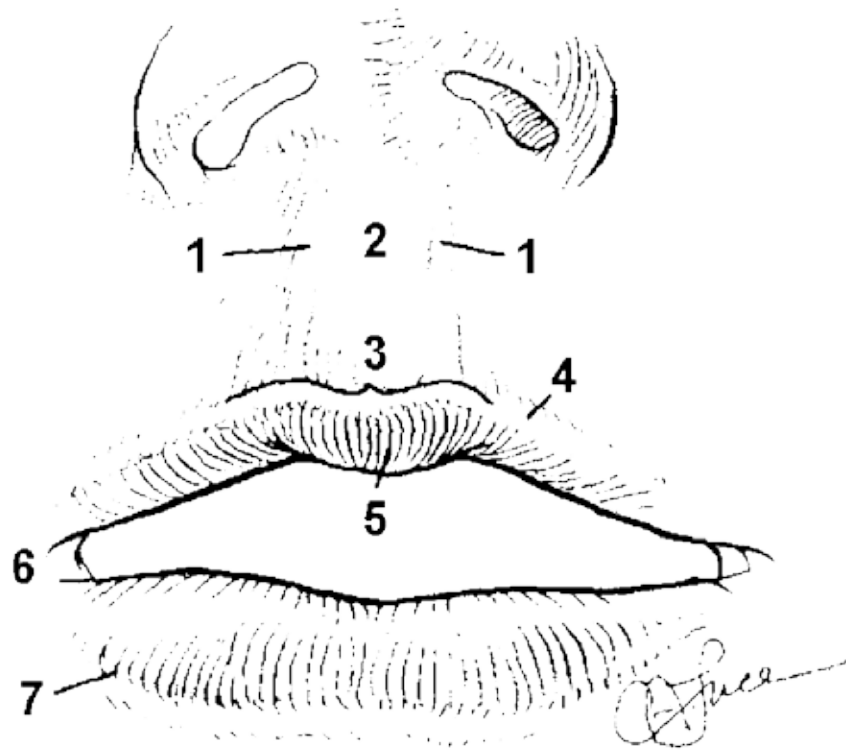
Plastic And Reconstructive Surgeon

Princess Alexandra Hospital

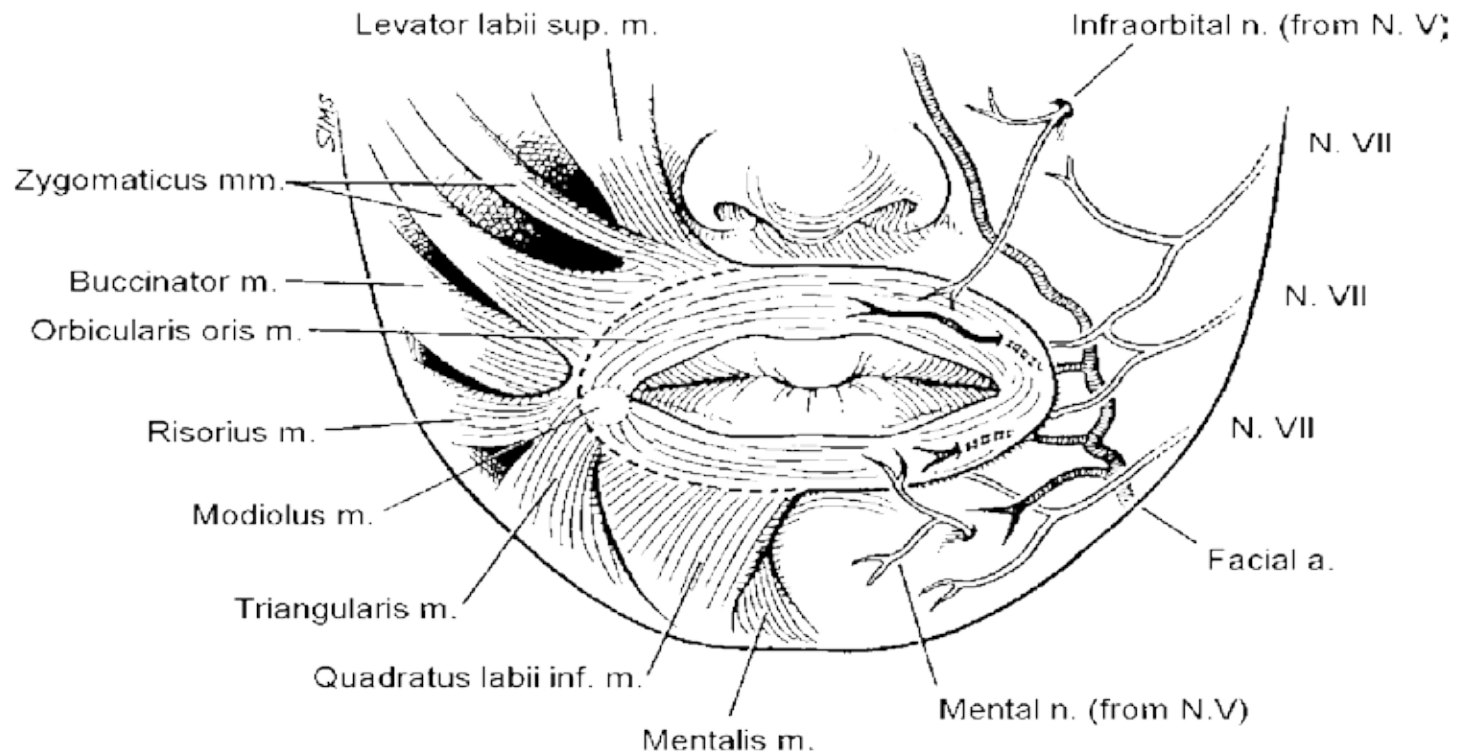
Lip Function

- Oral competence
- Aperture for Eating / Breathing
- Swallowing
- Speech
- Express emotion

Topography



Anatomy of Lip



Upper Lip Reconstruction

- *Aims*
 - The dentulous patient must be able to open his mouth sufficiently to provide access for dental repair
 - (Lip surgery has little long-term effect on speech, Patients who have reduction of lip sensation in addition to poor sulcus depth have a tendency to drool.)

Upper Lip Reconstruction

- *Priorities*
 - accurate approximation of the mucocutaneous junction
 - apposition of orbicularis oris
 - minimal distortion of the philtral complex

Upper Lip Reconstruction

- **Rule of thirds**
 - $<1/3$ 1° closure
 - $>1/3$
 - Abbe flap \pm peri-alar cheek advancement
 - Scalp visor
 - Forehead – laterally based
 - Abbe-Estlander
- Special case is Philtral region – Abbe Flap

Crescentic Perialar Flap



Total Upper Lip



Lower Lip Reconstruction

- **Rule of Thirds**
 - $< 1/3$ remaining lip (1° closure)
 - $1/3 - 2/3$ local tissue / opposite lip
 - $> 2/3$ cheek / distant
- commissure primary or secondary

Lower Lip Reconstruction

- *Goals*
 - Sensate
 - maintain sphincter or muscle function (orbicularis muscle. Reconstitution of the oral sphincter will depend on the precision of its repair.)
 - approximates to upper lip vermilion for watertight closure
 - sufficient opening for food and dental care
 - be of acceptable aesthetic appearance.
- Frequently, the procedure results in a tight, inverted lower lip that disappears beneath the curtain of the upper lip.

Lower Lip – less than 1/3

Wedge Resection

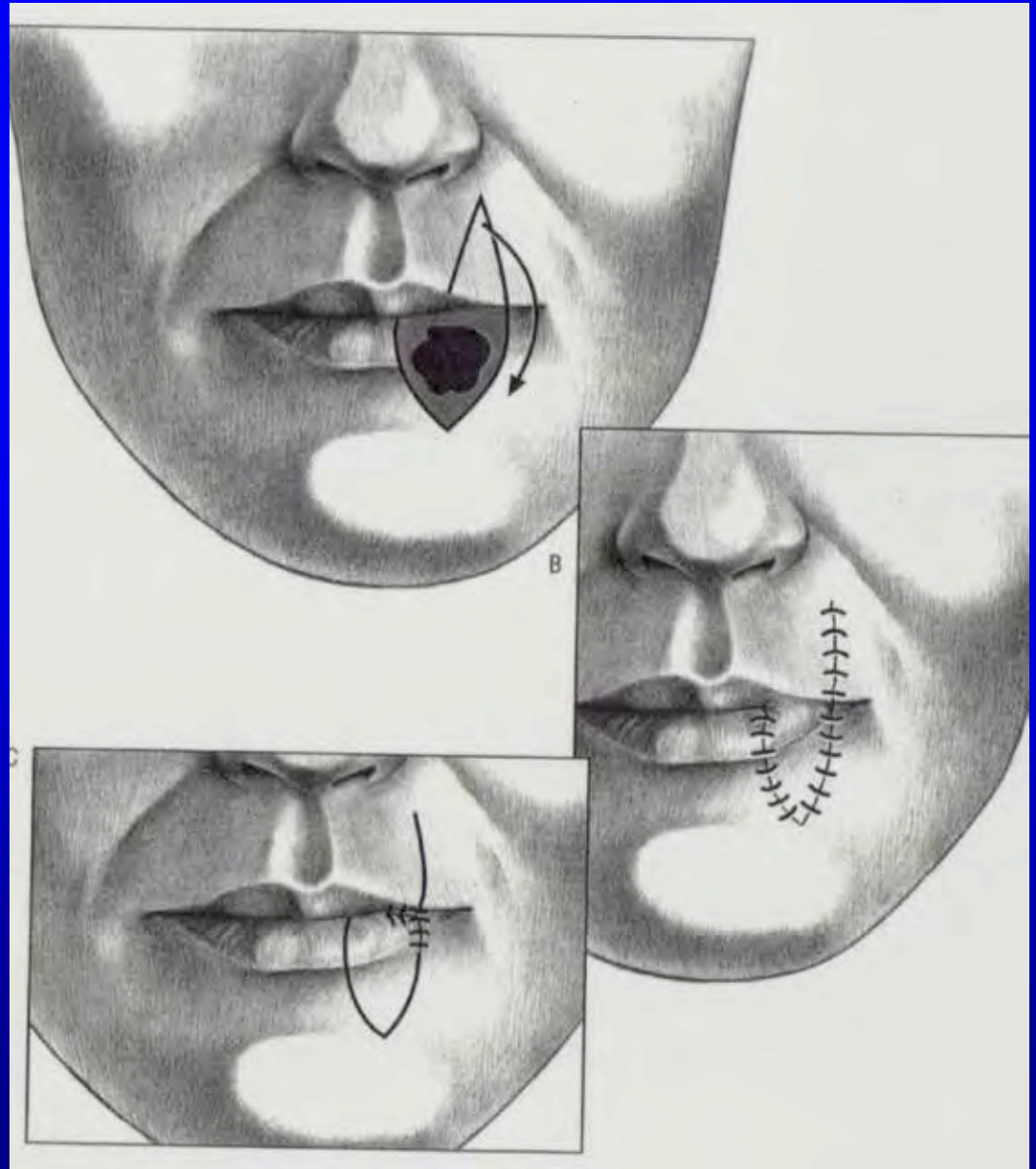
- Full thickness Excision as marked
- Repair in layers
 - 2 or 3 layer
 - Mucosa
 - Muscle
 - Skin
- Avoid notching



Lower Lip – 1/3-2/3

Abbe Flap

- Excision as marked
- Flap designed with the same height but *half* the width – allowing equal reduction in length of upper and lower lip
- Pedicle divided at 2 weeks (education of patient to allow nutrition)



Lower Lip

– 1/3-2/3

Abbe-Estlander Flap

- Commissure involved
- Flap is designed with height 1 to 2 mm greater than defect to be reconstructed.
- Need to be quite aggressive with thinning to allow reconstruction of commissure



Central Lower Lip

Bilateral Advancement flaps
- with Full thickness release
in the labiomental sulcus



Lower Lip

- >2/3

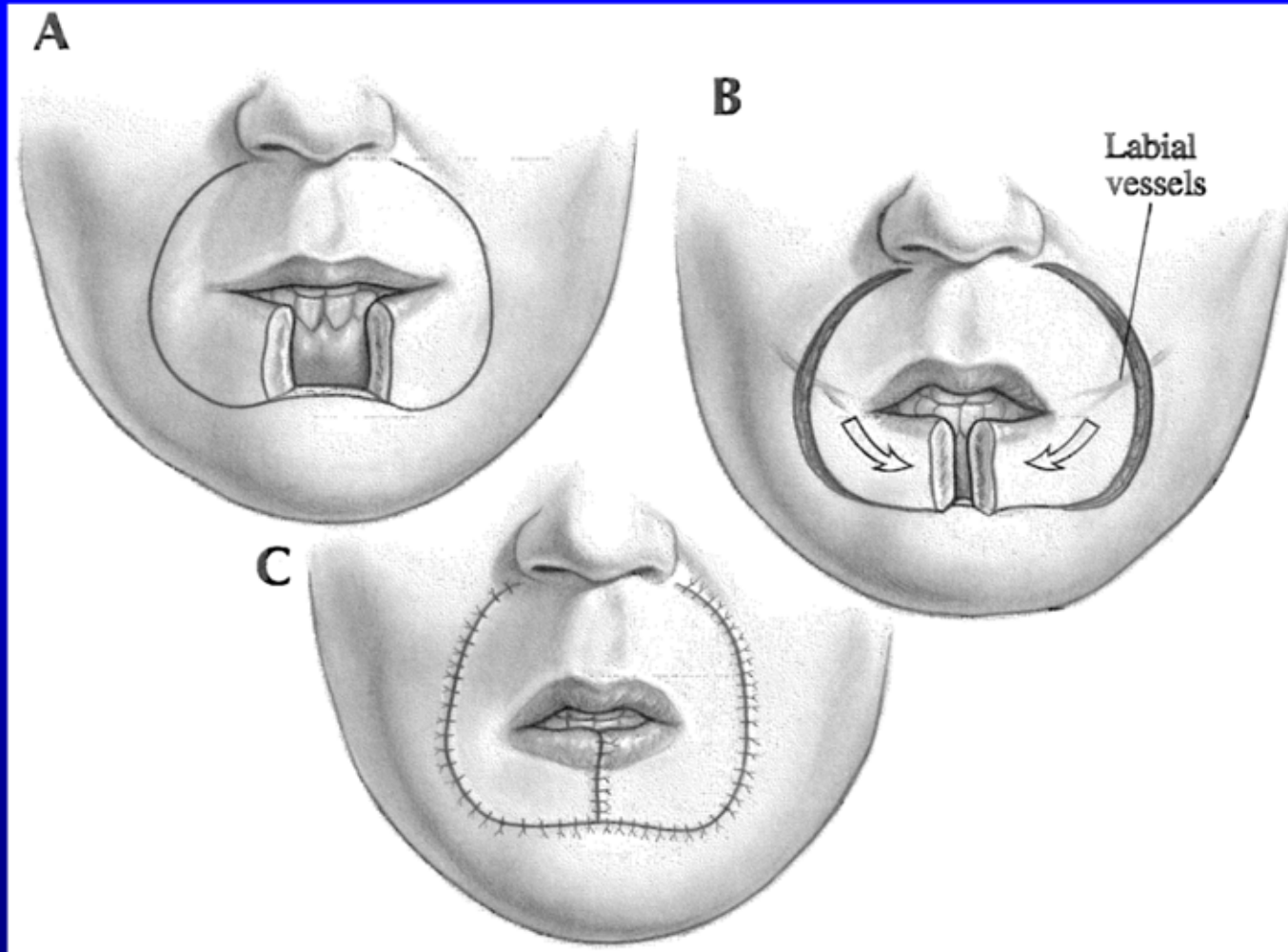
Karapandzic Flap

Webster Modification of
Bernard-Burow's Flap

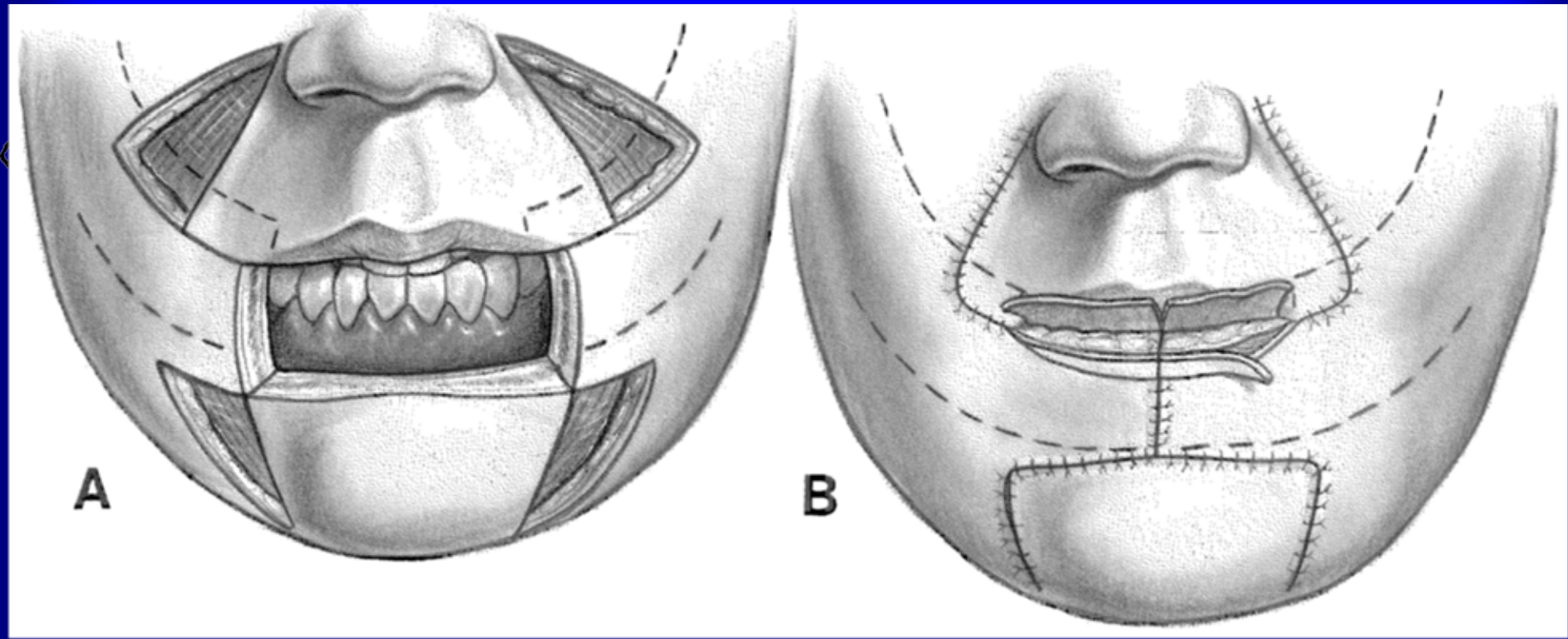
Gate Flap

Bilateral Abbe Flap

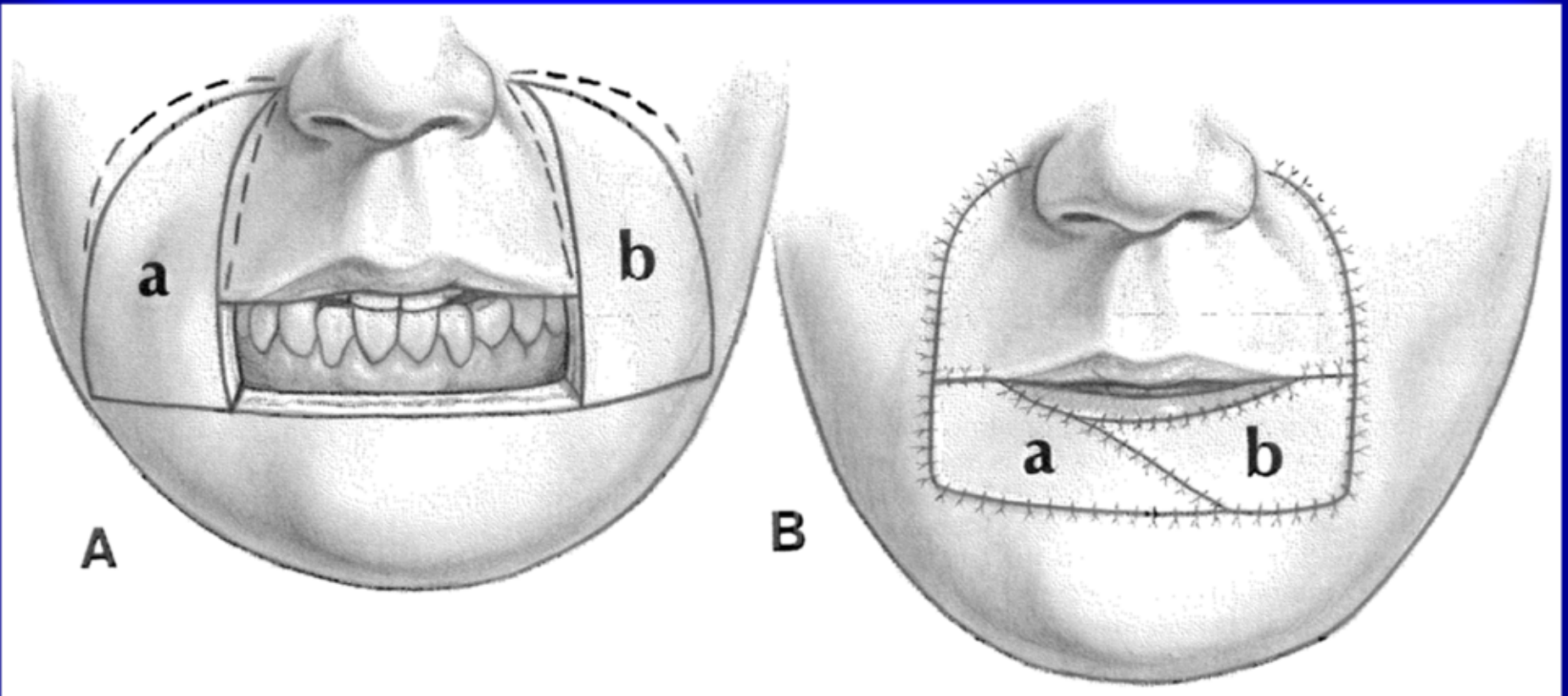
Karapandzic Flap



Bernard-Burow Flap (Webster Modification)



Gate Flap



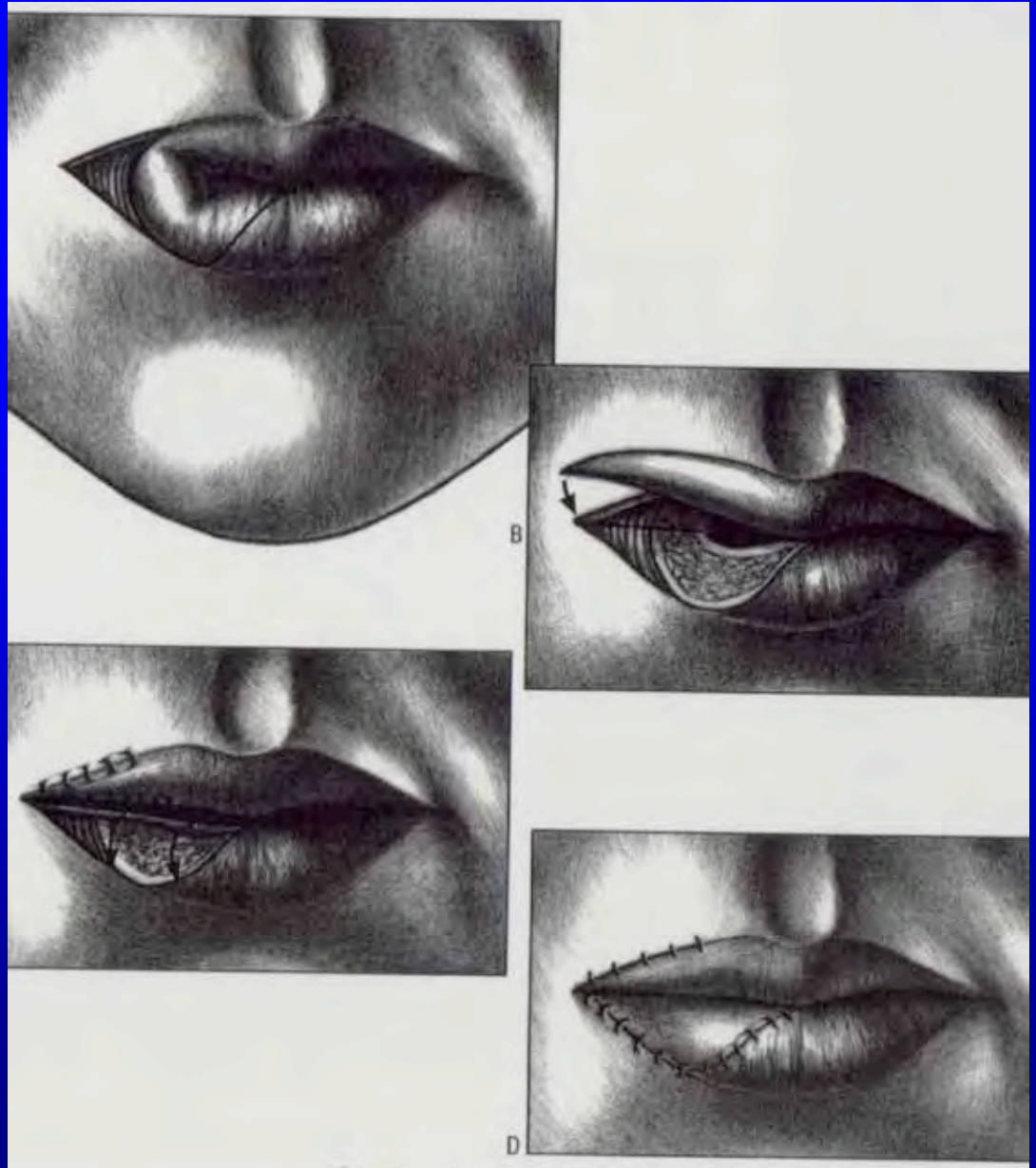
Bilateral Abbe Flap



Commisuroplasty

Converse

- A triangle of skin is excised to the depth of orbicularis oris muscle
- Muscle is split at the are of the oral commissure
- Mucosa from the lower lip segment incised, elevated superficial to muscle, and transferred to the new upper lip commissure
- Mucosa of intraoral lower lip is advanced outward to reconstruct lower lip oral commissure mucosa



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