Local Flaps and Mohs Reconstruction

GEORGE J. SCHMIEDER D.O., FACEP
I’ve been doing Mohs surgery since 2002
I have no conflict of interest with any drug companies.
This lecture is a review of Local Flaps in Facial Dermatologic Surgery.
This lecture is not designed to teach you how to do various Advancement Flap techniques, rather to refresh and explore just how complex Dermatology Surgery has become over the past 20 years.
There are various ways to approach closures, as many different Mohs surgeons sitting in the audience may agree.
I want to review with you some of the risks and benefits of doing different closures.
My hope is this lecture will assist our residents and some of you who are seeking re-certification with some board review gimme’s!
Introduction

Understanding Flap Repair status post Mohs surgery is a dynamic process and varies from patient to patient.

There are many different ways to approach repairing the surgical defect and I am not suggesting my way is the only way.

I always evaluate the risks and benefits of all repair options in every surgery case.

This allows me to maximize each repair success by going over the benefits and risks of the procedure with the patient and family as needed.
Flap Design

- When simple closure is not an ideal repair – due to size, tension, or poor cosmetic result.
- In this case, I suggest an “Adjacent Tissue Transfer” procedure, such as a flap.
- A Local Skin Flap is simply a portion of full thickness skin and variable subcutaneous tissue transferred from an adjacent donor site into the surgical defect.
- Nothing can be stressed more than communicating with your patient about the closure you are proposing to them. Have them sign consent forms for large defect repairs.
- Complicated repairs are always important to go over again, have an additional signature and acknowledge an additional family member or spouses approval.
K.I.S.S. Principle

“Keep It Simple Stupid”

- This may be my best advice to every person in the room when it comes to surgery, whenever possible, use the K.I.S.S. Principle.

- There are many risks to Dermatology surgery and flap repair.

- Risks include: pain, bleeding, infection, bruising, dehiscence and poor outcome scars. Every one of these and more should be listed in your consent form.

- I cannot stress going over your consent with every patient. Just do it! With each patient one on one. In a court of law this will save you!
Mohs Consent

<table>
<thead>
<tr>
<th>OPERATION or PROCEDURE:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Mohs Surgery</td>
<td></td>
</tr>
<tr>
<td>Frozen Excision</td>
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1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

Under the administration of local anesthesia, remove lesion from:

LOCATION(S):

Possible Risks: Bleeding, Infection, Scarring, Recurrence, Allergic Reaction to Anesthesia, including Sudden Death.

Which is to be performed by or under the direction of:

- ☐ George J. Schmieder, DO
- ☐ Karthik Krishnamurthy, DO
- ☐ Sarah Ferrer-Bruker, DO

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the above-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the above-named medical facility.

4. I request the disposal by authorities of the above-named medical facility of any tissues or parts, which may be necessary to remove.

5. I understand that photographs and video may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of operation by authorized personnel, subject to the following condition:

6. Said pictures and video are to be used only for the purpose of medical evaluation and billing.

PROCEDURE SITE VERIFICATION CHECKLIST:

<table>
<thead>
<tr>
<th>YES / NO</th>
<th>Initial site identification. If No, Patient Safety time out called</th>
<th>Witness Signature</th>
<th>Patient Signature</th>
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<tbody>
<tr>
<td></td>
<td>Procedure Site identified verbally by:</td>
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</tr>
<tr>
<td>YES / NO</td>
<td>Procedure Site confirmed verbally by Physician:</td>
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1. **Counseling Physician:** I have counseled this patient as to the nature of the proposed procedure(s) attendant risks involved, and expected results, as described above.

   **Physician Signature**

2. **Patient:** I understand the nature of the proposed procedure(s), attendant risks involved, and results, as described above, and hereby request such procedure(s) be performed.

   **Patient Signature or Guardian**
   **Date**
   **Witness Signature**
   **Date**
K.I.S.S. Principle
“Keep It Simple Stupid”

- This is the simply the best advice I can give you as an experienced Mohs surgeon. Always have a trusted staff to help ensure you are obtaining the patient’s consent to surgery.

- Always take a time out and be sure the consent form has been signed before you start every surgery. Remember, as the surgeon, the consent is your responsibility no matter how busy you become.

- Never start a surgery without checking the consent being signed and at least briefly going over with your patient.

- Don’t be afraid to take a time out before you MAKE the excision. 60 seconds is all it takes!
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Pre-op BCC
4 stage immediate post-op
Before we get started lets take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
4 week post-op
6 week post-op
2 month post-op
2 month post-op
Excision of Scar
Pre-Test

Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Xenograft/Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Large Recurrent Sclerosing BCC
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Xenograft/Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Left temple
4 stage Mohs post op
Left temple
Day of surgery post-op
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Xenograft/Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Day of surgery after completion of Xenograft
Xenograft close-up
After completion
2 month post surgery
Close up 2 month post surgery
Advancement Flaps

- A Rotation Flap is a random pattern flap where the motion or movement is in a rotating fashion.
- The primary movement of an Advancement Flap is the one dimensional sliding of tissue directly into a defect. This helps redistribute the excess tissue.
- Advancement Flaps have many variations which we will go over in the following slides. They include Single and Bilateral Advancement Flaps as well as Island Pedicle flaps.
Advancement Flaps

- A large single Advancement Flap is often performed on the cheek. These are used to repair medium to large defects of the medial cheek and lateral portion of the nose.

- The next patient has a large defect on the lateral portion of the nose. The incision is placed in the alar crease and nasolabial fold by removing tissue above and below the defect to allow the cheek to advance into the Nasolabial sulcus.

- Depending on the size of the defect sometimes it is necessary to take down the Flap to the periosteum at the nasal sidewall-cheek junction to take pressure off the leading edge and recreate the natural concave surface of the face, which helps to prevent webbing in the nasolabial fold.
Large KA SCC of Sidewall
1 stage
Immediately after Closure
Infiltrative BCC
Left alar crease
2 stage
Post Mohs
Closure
Nasal sulcus left open to heal by secondary intention
Helical Rim Advancement Flap

- Used to repair defects of the Helical Rim.
- This is an incredible Flap for mid and lower Helical rim defects.
- This may be my preferred closure for the Helical Rim.
- Of course, remember the K.I.S.S. principle so a complex closure is always considered first by trying to undermine surrounding tissue and pull the edges together but, when the defect is too large for a complex closure on the helical rim.
- Then the Helical Rim Advancement Flap is the winner!
Micronodular BCC
Lower Helical Rim
Closure after 3 stages of Mohs
Closure after 2 stages of Mohs SCC
Closure after 2 stages of Mohs SCC
Bilateral Advancement Flap or H-Plasty

- Not one of my favorite Flaps.
- I’ve only used them on large scalp and forehead defects. Sometimes they can be very successful when used on the eyebrows.
- Cosmetically it’s really difficult to hide this Flap on the forehead and scalp and should be one of your last resorts.
- Use it only when having a difficult time in moving tissue.
Crescentic Advancement Flap

- Its two primary functions are to repair the upper lip and with many nose defects to preserve the Ala.
- So that the superior scar line is placed in the perinasal sulcus.
- This is a complicated difficult repair and I wouldn’t recommend this for anyone who doesn’t have a great deal of surgical experience. This is time consuming and carries with it more risk.
- This flap is particularly useful for the repair of the upper lip, as I will show in the next slide.
- Also useful in the Perialar area with large defects.
28 yowf
Infiltrative BCC
Infiltrative BCC
S/P 3 stage Mohs
Immediate post-op
Front View
Immediate post-op
Side View
One week suture removal
One week suture removal
Close up
Six week suture removal
Front View
Six week suture removal
Side View
Island Pedicle Flap

- Referred to as V to Y Advancement Flap.
- This has become a coding nightmare and CMS wants a named artery when using this closure. Including detailed photos of course! Example, when doing an Island Pedicle Flap in the nasolabial fold you need to name the superior labial artery.
- The Island Pedicle Flap is most commonly done on nasal and perinasal closures where free margins are at risk for distortion.
Island Pedicle Flap

(a) Surgical defect

Extent of retained vascular pedicle of the island pedicle flap

(b) Flap sutured into place

Suture direction x→y
Island Pedicle Flap
O-T/O-L Advancement Flap

- An L-plasty or what we commonly refer to as an O to L Advancement is a single tangent flap.
- An incision is made at one end of the defect, extending outward for some length. The mobilized tissue is then advanced into the defect.
- Tissue redundancy is created on the side of the defect opposite the Flap Incision and must be removed or carefully sewn out.
- I use this with large distal nasal sidewall defects.
Left temple
Pre surgery and post surgery
Left temple
Pre surgery and post surgery
Left temple
Post-op
Left mid infraorbital rim SCC
Post-op
Left mid infraorbital rim SCC
Post-op
East-West Advancement Flap

- Modified burrow advancement Flap
- This is used extensively for small nasal tip defects to disrupt the straight line effect and create a more natural wave in the closure.
- Almost all of my older men will require some follow up Dermabrasion or Fraxel laser resurfacing.
East-West Advancement Flap
Right bridge of nose
Pre surgery
East-West Advancement Flap
Right bridge of nose post surgery
East-West Advancement Flap
Left alar crease
Closure
East-West Advancement Flap
Left mid forehead/Left upper forehead medial
SCC Pre-surgery
East-West Advancement Flap
Left mid forehead/Left upper forehead medial
Combined Closure
East-West Advancement Flap
Left mid forehead/Left upper forehead medial
Combined Closure
Rotation Flap

- Rotation Flap is a random pattern flap.
- The primary movement of the Rotation Flap is the sliding of tissue about a pivot point into the defect.
- This will help redistribute wound tension as well as tissue redundancy.
- There are several variations including Single and Bilateral Rotation Flaps as well as Dorsal Nasal Flaps.
Dorsal Nasal Rotation
AKA The Rieger Flap

- This Flap is used to repair nasal defects involving the nasal dorsum or nasal tip.
- The tissue reservoir of the nasal root and glabella allows for the movement of the dorsal nasal skin superior to the defect.
- A long sweeping arc is created that extends into the nasolabial sulcus and terminates in the glabella.
- A back cut in the glabella improves the rotational mobility of this flap and is termed a Hatchet Flap.
- If the arc of the Flap is not long enough there will be too much tension and you will see elevation of the nasal tip.
Dorsal Nasal Rotation
AKA The Rieger Flap
Rotation Flap/ AKA Rieger Flap

Mid tip large nodular BCC
Rotation Flap/ AKA Rieger Flap
Mid tip large nodular BCC
Close up
Rotation Flap/ AKA Rieger Flap
Rotation Flap/ AKA Rieger Flap

At close
Rotation Flap/ AKA Rieger Flap

Close up
Rotation Flap/ AKA Rieger Flap

Surgery if flared nostrils
Transposition Flaps

- Primary movement of a Transposition Flap is not merely sliding but picking up the Flap and transposing over the intervening tissue, redistributing tension vectors.

- There are several versions of Transposition Flaps. The most commonly used in my daily surgery clinic are Bilobed Flaps.

- The other Rhombic and Banner will be discussed briefly.
Transposition Flaps

- Simply put, Transposition Flaps transpose loose adjacent skin over an Island of normal skin to the site of the Mohs defect.
- Transposition Flaps are usually smaller than advancement and rotation flaps.
- The resulting scars are geometric broken lines that may be less noticeable than longer linear closures.
- One of the biggest advantages of Transposition Flaps are that they utilize adjacent skin and provide excellent color and texture match.
- This is particularly true on the nose where a Bilobed Flap can have a far better outcome than a graft from a distant site.
Bilobed Flaps

- Although this is a frequently used Flap in our clinic, I consider this Flap a highly technical and skill oriented Transposition Flap.
- Consists of two Transposition Flaps executed in succession which follow the same direction of rotation over intervening tissue.
- Basic premise is to fill the defect with the primary lobe, while filling the secondary defect with the secondary lobe which leaves a triangular shaped tertiary defect to be closed primarily.
Bilobed flaps
Supratip nose
Pre-op
Supratip nose
Post-op
Supratip nose post surgery
Supratip nose post surgery
Supratip nose
3 stage infiltrative BCC
Post-op
Supratip nose
3 stage infiltrative BCC
Post-op
Supratip nose
3 stage infiltrative BCC
Closure
Banner Flaps

- A Random pattern finger shaped cutaneous flap that, like other transposition Flaps, tap into adjacent skin to borrow laxity and fill a defect.

- Most commonly planned as a melolabial transposition to repair defects of the nasal ala or from the pre or post auricular area to close defects on the ear.

- To minimize risk of vascular compromise the Flaps are typically designed to rotate through an angle of 60-120° instead of the originally described 180°
Banner Transposition flap
Bilateral Rotation Flap

- Sometimes due to the size of the defect or the potential tension, the flap mandates a Bilateral Rotation Flap.
- Where tissue is rotated into a defect from two opposite sides.
- The vectors of rotation often may be mirror images of each other.
- This is often used in large defects on the scalp, as I will show you.
- When the vectors of movement are in opposition, this creates an O to Z flap.
Bilateral rotation flaps
Large SCC scalp
3 stage Mohs
Immediate post-op
The rotation vector drawn out
Undermining tissue
Closure of defect
Bilateral Rotation Flaps

- Besides being useful for scalps let me show you some examples of the lips.
Right mid upper lip
Pre surgery
Right mid upper lip
Post surgery
Right mid upper lip
Closure
Right mid upper lip Closure
Rhombic Flaps

- Designed by conversion of the primary defect into a four-sided parallelogram with each size of equal length and tip angles of 60° and 120°.

- This rhombus forms the recipient site for the flap as well as the template on which to plan the flap incisions.
Rhombic Flaps
Import pedicle tissue from a site distant to the defect.

These are considered Axial Flaps that can support a larger mass of tissue compared to the other random flaps.

These Flaps are used to repair defects distant from the donor site.

The vascular pedicle must be temporarily left in place to ensure adequate blood supply.

This means it requires more than one stage to complete the repair.
Many interpolation flaps may be classified as axial flaps if their vascular pedicle is based on a large, named artery.

The 1st stage of an interpolation flap involves the design and creation of the flaps.

The 2nd stage involves the takedown of the flap in which the pedicle is incised and removed, while the residual tissue is sewn into the defect and the donor site is closed primarily.
Paramedian forehead flaps are useful to repair large deep nasal defects.

Tissue is mobilized from the forehead based on one of the supratrochlear arteries.

Then transposed to the large distal nasal defect with the pedicle remaining attached in the glabellar region.

It takes 2-3 weeks until the pedicle is separated from the brow.

Many Mohs surgeons do these in the office setting.

I personally prefer a surgical center with IV conscious sedation.
Paramedian Forehead Flap
Paramedian Forehead Flap
Nasolabial Interpolation Flap

- This Flap is utilized to repair defects of the ALA, particularly in instances where cartilage grafting is required to restore the structural integrity of the alar rim.

- This Flap is harvested from the medial cheek and nasolabial fold and is based on branches of the angular artery.
Nasolabial Interpolation Flap
Nasolabial Interpolation Flap
ABBE Flap

- Also known as the lip-switch Flap and is reserved for repair of large, deep defects, typically of the upper lip.
- Particularly useful for defects that involve up to half of the lips without crossing the midline.
- The flap is harvested from the ipsilateral lower lip and is based on the inferior labial artery.
- The artery is located deep to or within the orbicularis oris muscle and runs along the mucosal aspect of the vermillion border.
ABBE Flap

- This defect should be full thickness including muscularis and oral mucosa.
- It is rotated upon a vascular pedicle that makes up the lateral aspect of the flap.
- The inferior labial artery will be visualized as it is transected at the mobilized edge of the flap.
- The donor site is undermined and closed first to facilitate freeing up the flaps.
- This should be closed in layers such as one would do in a wedge resection: mucosa, muscularis, subcutaneous, then cutaneous.
Lastly the flap will be rotated superiorly and also inset with a layered closure.

The key to this closure as is any closure around the mouth is the alignment of the vermillion borders both at the donor site and defect.

As with other Interpolation flaps the pedicle will remain in place for at least 3 weeks.
ABBE Flap
Retroauricular Flap

- Also a 2-stage Interpolation flap used for large defects of the helix.
- Defects in this location typically involve the perichondrium are not suitable for grafts.
- Considered a Random Flap as it is not based on a large named artery.
- It is harvested from the richly vascularized skin of the postauricular scalp and is advanced over intervening intact skin to fill the helical defect.
- Like all interpolation flaps the pedicle remains attached to the posterior scalp for 3 weeks.
- This Flap often comes with post-op bleeding and much discomfort. Never do this flap on a Friday afternoon.
Retroauricular flap

- The donor site is not repaired until pedicle take-down and often, due to its inconspicuous location, is left to heal secondarily.
Postoperative Care

- Meticulous postoperative wound care is necessary to ensure an optimal outcome.
- Verbal and written instructions regarding home wound care should be reviewed and then provided in writing to the patient.
- Every Interpolation Flap needs a pressure dressing should be applied and left intact for 48 hours.
- We have everyone change the bandage after 48 hours and reinforce the importance that the wound must be kept clean, moist and covered until sutures are removed.
- This promotes epithelialization, reduces the chances of infection and will help eliminate desiccation.
- Most importantly it will aid in hemostasis.
Postoperative Care

POST-OP WOUND CARE INSTRUCTIONS

Patient’s Name: ____________________   Date: ____________   DOB: ____________

Please Print.

You have just had a minor surgical procedure. Sutures may or may not have been placed depending on your procedure. The following recommendations are made so that the wound will have less chance of becoming infected and the best chance for adequate healing.

1. Keep the bandage clean and dry for 24 hours. The bandage may be removed after 24 hours.

2. Gently cleanse wound using mild soap and water. It is ok to shower, but avoid immersing the site into water (no swimming pools, hot tubs or bath water) for 2 weeks.

3. Dry area around wound and apply Aquaphor® or petroleum jelly (Vaseline®) to completely cover the wound and then apply a small adhesive bandage, or Band-Aid®. If an adhesive bandage will not fit the wound, you may purchase a non-stick pad such as Telfa® over the counter. Cut the Telfa® down to wound size and secure with paper tape.

4. Repeat the cleaning, ointment application, and bandaging twice a day until sutures are removed or until the wound is completely healed with pink scar tissue. Keeping the wound moist with ointment until healed will expedite healing and decrease scarring. Do Not let the wound dry out. It does not need to develop a scab/crust as this will delay healing.

5. Antibiotic ointments, hydrogen peroxide and alcohol are not recommended and should not be used on your wound.

6. To minimize swelling and bruising, an ice pack may be used. Apply over bandaged area for 10 to 15 minutes and repeat every hour for the first 24 hours.

7. Even the best cared for surgical wound may become infected. Signs of infection include: swelling, pain, redness and oozing pus. If these signs appear, you should call the office at (904) 541-0315 for a same-day evaluation. Weekends / holidays or after hours, please call (904) 541-0315 and leave a message with our answering service. Our on-call provider will be paged and directed to return your call.

8. Almost all surgical wounds may bleed a small amount during the first 24 hours. In the unlikely event that bleeding is more active, direct firm pressure applied to the site using clean gauze or tissue for about 20 minutes should stop the bleeding. If this does not stop the bleeding, repeat holding continuous pressure for an additional 20 minutes, and notify our provider on call.

9. Minimize activities that may over stress the surgical site. Excessive movement and stress to the site may result in poor healing and could lead to the sutures pulling apart. If a splint is applied, please follow your instructions.

Special instructions: ____________________________________________

_____________________________  __________________________
Patient or Guardian’s Name        Date

_____________________________  __________________________
Guardian’s Name if appl.                Date

_____________________________
Witness Signature

_____________________________
Print Witness Name

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- Pain
- Infection
- Flap necrosis
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Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right temple
Pre surgery
10/03/2016
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right temple post surgery
10/03/2016
Before we get started, let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right temple
Pre surgery and post surgery
10/03/2016
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right upper lip
Pre surgery
01/13/2017
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right upper lip post surgery
01/13/2017
Before we get started lets take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right upper lip
Crescentic Advancement Flap
01/13/2017
Right upper lip
Crescentic Advancement Flap
01/13/2017
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right superior helix
Pre surgery
12/05/2016
Right superior helix
Pre surgery
12/05/2016
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right superior helix
Post surgery
12/05/2016
Before we get started lets take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right superior helix
Bilateral Helical Rim Advancement Flap
12/05/2016
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Left mid nasal dorsum
Pre surgery
11/23/2016
Before we get started lets take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap  
B. Rotation Flap  
C. Secondary Intention  
D. Advancement Flap  
E. Interpolation Flap
Left mid nasal dorsum
post surgery
11/23/2016
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Left mid nasal dorsum
O-L Advancement Flap
11/23/2016
Left mid nasal dorsum
O-L Advancement Flap
11/23/2016
Before we get started lets take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Left lateral zygoma
Pre surgery
08/08/2014
Left lateral zygoma
Pre surgery
08/08/2014
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Left lateral zygoma
Rhombic Transposition Flap
08/08/2014
Left lateral zygoma Rhombic Transposition Flap
08/08/2014
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right nasal tip
Pre surgery
09/26/2016
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right nasal tip post surgery
09/26/2016
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
Right nasal tip
Bilobe Transposition Flap
09/26/2016
Before we get started lets take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
S/P 12 stage Mohs Infiltrative BCC
S/P 12 stage Mohs Infiltrative BCC
S/P 12 stage Mohs Infiltrative BCC
Before we get started let's take a look at one of my cases and think of how you might approach closing this case.

A. Transposition Flap
B. Rotation Flap
C. Secondary Intention
D. Advancement Flap
E. Interpolation Flap
10 years post-op
Close up
10 years post-op
10 years post-op