

Anchored Rotation Flap for Cheek Prevents Ectropion

BY SHARON WORCESTER
Southeast Bureau

ATLANTA — A novel anchored rotation flap for infraorbital cheek reconstruction allows full defect repair without causing lower-lid ectropion, Dr. Kord Honda said at the joint annual meeting of the American Society for Dermatologic Surgery and the American College of Mohs Micrographic Surgery and Cutaneous Oncology.

The technique involves the use of an anchoring suture to allow an inferiorly based rotation flap for horizontal defects of the midpupillary and medial infraorbital cheek. The suture allows horizontal redirection of the flap tension vectors, which helps prevent ectropion, explained Dr. Honda, a dermatology resident at the University of Washington, Seattle.

In four patients with defects ranging in size from 1.4 by 2.9 cm to 2.4 by 3.4 cm, outcomes at up to 3 months were excellent, with no evidence of lower-lid ectropion, he said.

The long axes of the defects in all four patients were horizontally oriented: Two

were centered on the midpupillary line, and two were located medially.

The patients first underwent Mohs surgery for complete skin cancer removal; then the edges of the defect were made perpendicular. An incision was made to the midsubcutaneous fat at a 90-degree angle along the nasofacial sulcus and extended into the melolabial fold if necessary.

The flap, designed to rotate tissue from the inferior aspect of the defect, was undermined with sharp dissection in the midsubcutaneous fat. The anchoring suture was placed first and served as the key stitch. This suture was placed from the superior medial portion of the flap into the periosteum of the superior nasal sidewall or medial maxilla, Dr. Honda reported.

Testing for ectropion and eclabium was performed. The wound edges were approximated with a running 5-0 or 6-0 nylon suture with tension placed horizontally to prevent ectropion.

This anchored rotation flap is a one-stage procedure that preserves the eyelid margin and is ideal for horizontally oriented defects, he said. ■

Patients' Psoriasis Improves After Single Dose of Excimer Laser

BY PATRICE WENDLING
Chicago Bureau

CHICAGO — A single 10 minimal erythema dose from an excimer laser can safely and effectively treat moderate to severe plaque psoriasis, Kevin D. Cooper, M.D., said at the 11th International Psoriasis Symposium sponsored by the Skin Disease Education Foundation.

The 308-nm XTRAC excimer laser treatment system (PhotoMedex, Montgomeryville, Pa.) is the first laser treatment approved for psoriasis.

It offers an obvious advantage over conventional phototherapy because it can target lesional skin with a higher initial dose of ultraviolet radiation, he said.

What hasn't been known is the optimal dose needed to treat moderate to severe psoriasis.

A minimal erythema dose (MED) of 4-16 has been used. But crusting of the involved skin can occur if the dose exceeds 10 MED, said Dr. Cooper, professor and chair of dermatology at Case Western Reserve University, Cleveland.

In a study that was led by his former

colleague Mark Kagen, M.D., 15 patients with a mean Psoriasis Area and Severity Index (PASI) score of 18.9 and a lesional thickness of 168 μ m were treated on the trunk and extremities with a single dose of 10 MED from the XTRAC excimer laser.

Patients responded rapidly at 2 and 4 weeks post treatment. On average, PASI scores were reduced from 18.9 at baseline to 8 by week 8.

"What's remarkable is that this is a single dose," Dr. Cooper said.

The response was limited to the area treated, but improvement was noted in patients of all skin types, including Fitzpatrick skin type V.

Biopsies were performed on lesions in eight patients. Lesion thickness decreased, and depletion of epidermal and dermal T cells also was observed. T-cell counts decreased from 50-55 at baseline to 15 at 8 weeks post treatment.

Dr. Cooper and Dr. Kagen, now in private practice in Orlando, do not have a relevant conflict of interest.

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