THE CERVICAL MUSCULAR FLAP IN RECONSTRUCTION OF THE ORAL AND CREVICAL DEFECTS

M. RUSU

PhD candidate of “Lucian Blaga” University in Sibiu

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Abstract: Patients with large oral and cervical defects after excision of malignant tumours will present different degrees of functional and aesthetic impairment. From the myriad of reconstructive options the sternocleidomastoidian muscle flap becomes an accessible, easy to perform and predictable solution. The major criteria of exclusion from the reconstructive plan are represented by the adherent cervical adenopaties to the muscle. Being a versatile solution it can be used in composite defects utilizing skin, fascia, muscle and even bone.

Keywords: tumori, lambou muscular, reconstrucție

Rezumat: Pacienții cu defecte extinse oro-cervicale în urma exciziei tumorilor maligne vor prezenta diferite grade de afectare funcțională și estetică post ablație. Din multitudinea de opțiuni de reconstrucție lamboul mușchiului sternocleidomastoidian se impune ca o variantă accesibilă, ușor de efectuat și prelevabil din zona adiacentă. Criteriul de excludere major în opțiunea de reconstrucție cu acest mușchi este reprezentat de existența adenopatii laterocervicale aderente mușchiului. Fiind o soluție versatilă poate fi folosită în defecte compozite utilizând tegument, fascie, mușchi și chiar și os.

INTRODUCTION

The sternocleidomastoidian muscle constitutes the lateral from of the neck. In case of neck metastases frequently encountered in the tumoral pathology of the oropharynx when we can approach the case in a conservative manner the muscle is spared thus offered for a reconstruction solution(1).

Technical aspects

The vascular source is offered by three pedicles, dominants being the middle and the superior ones(3). The sternocleidomastoidian muscle can be imagined in four ways as a flap: muscular flap, musculocutaneous flap, musculoperiosteal flap or osteomuscular flap with clavicle raising either continuous either splitted.

First we are going to dissect the sternal and clavicular head going upwards to the level where the arch of rotation is going to permit the insertion of the muscle in the defect. Saving the superior thyroid artery is a must in order to save as much as possible of the muscle vascular inflow(4).

The mucosal edges are going to be sutured by overlapping wide with the muscle. This one is going to heal excellent by means of secondary intraoral epitelisation but also can be covered with a splitted skin graft.

Figure no. 2. The muscular flap applied in the orpharyngeal defect (SCM), Cheek flap(LG), Tongue strap(L)

The indications in using this flap are the reconstruction of small or middle sized oral cavity defects, tunneled to the level of floor of the mouth can be applied also in
oropharyngeal defects (5). The donor place can be sutured in most of the cases primarily or with local or regional solutions of rotated flaps. The literature studies which compare the inferior or superior flap raising do not show significant survival rates between but the skin island in the majority of the cases suffers necrosis (6).

The most important aspect in raising this flap is local or regional reconstructive solution also in the case of patients previously irradiated.

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