

for colorectal cancer, as it is possible to detect and treat previous precancerous pathology of the rectum in a timely manner.

Conclusions

The short-term results of treatment of patients with cancer of the lower ampulla of rectum can be considered satisfactory. The frequency of postoperative complications was 6.8 %, postoperative mortality was 1.1 %.

LITERATURE

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ANALYSIS OF IMMEDIATE OUTCOMES AFTER NASAL RECONSTRUCTION USING FOREHEAD FLAP

Introduction

Surgeons from a great number of specialties are now commonly performing nasal reconstruction procedures to repair deformities resulting from trauma, carcinoma and rhinophyma. There are several options for reconstructing the nasal lining, including mucosal flaps, skin grafting, local flaps, prefabricated forehead flap, three-stage forehead flap, forehead flap turnover, and free tissue transfer. Although performed more commonly, nasal reconstruction is considered to be an operation with risks including negative cosmetic result, infections, extrusions, atrophy, fibrosis, numbness, graft protrusions and necrosis. Out of all the options for nasal reconstruction, forehead flap is the oldest and most cosmetically positive surgical technique. It provides the surgeon with a strong pedicle, a large amount of tissue to reconstruct almost any defect with less complications. A well-executed forehead flap can result in the most natural-appearing, durable, and inconspicuous, nasal reconstruction. In terms of color and texture, there is no other flap that approaches its suitability for skin matching. The only significant limitations of the flap are the investment of time and the morbidity involved in the necessary staging of the operation. Since its found, the forehead flap has undergone a number of changes, making it the optimal choice for large nasal defects. It is traditionally used for nasal defects that are too large to repair with other local flaps or full-thickness or composite grafts. A defect wider than 2 cm in the horizontal plane or those with exposed and denuded bone and or cartilage are best repaired with the paramedian forehead flap. It should however be considered the gold standard for all nasal reconstruction.

Goal

The purpose of this article is to discuss the main causes of nasal defects which leads to nasal reconstructions and to discuss the outcomes of using forehead flaps and there relation to possible risk factors, age and gender of the patients

Material and method of research

Total number of 53 patients that underwent nasal reconstruction surgery in the Gomel Regional Clinical Center from were taken into consideration from the age of 9 to 89 out

of whom are 25 female and are 24 male. Average age of the patients is 62. Age to gender distribution is presented in Figure 1. Causes for nasal defect included carcinoma removal, secondary defect following carcinoma treatment, trauma and rhinophyma. Nasal defect cause distribution is presented in table 2. By the size of defect distribution large and small, by site lower and upper, by depth superficial and full thickness are included. Out of all the patients considered, 32 % patients were without known risk factors and rest were presented with diabetes, smoking and radiotherapy. We analyzed total rate of surgical complications and their types, rate of complications separately after reconstruction depending on defect type.

The result of the research and their discussion

Out of the total 53 patients that were taken into consideration, 25 were female and 24 male. The average age of the considered group is 62. The age gender distribution graph is presented in Figure 1.

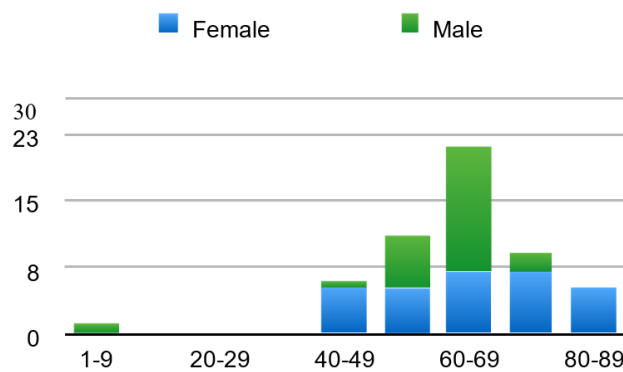


Figure 1 – Age to Gender distribution

The causes of the nasal defects that lead to nasal reconstruction are presented in Figure 2.

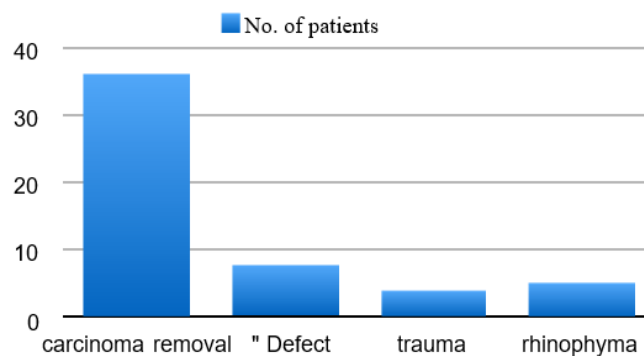


Figure 2 – Nasal defect cause distribution

Out of the considered 53 patients, 7 (13.2 %) had complications after the surgery, which included 71.42 % of partial flap necrosis and 28.57 % of graft protrusion. 71.4 % of the complications were in males and only 28.5 % were of females. 11.58 % out of all superficial defects had complications, all were partial flap necrosis. 14.81 % out of full thickness defects had complications. 50 % were graft protrusion and 50 % were partial flap necrosis. 15.15 % out of all lateral defects had complications. 40 % were graft protrusion and 60 % were partial flap necrosis. 10 % out of all central defects had complications. 100 % were partial flap necrosis. 11.11 % out of all small defects had complications. 33.33 % were graft protrusion and 66.66 % were partial flap necrosis. 15.38 % out of all large defects had complications 25 % were graft protrusion and 75 % were partial flap necrosis. 71.4 % of all the cases with complications had

risk factors amongst which, 60 % were previous radiotherapy and 40 % cases smoking. Out of the five partial flap necrosis cases, direct suturing was done for one donor wound closure and for the other four cases, skin grafts were used. For both graft protrusion cases, per secondarem was used for donor wound closure.

Conclusion

Complications arising after nasal reconstruction surgeries are at a rate of 13.2 %, and more than 70 % of the cases with complications are associated with known risk factors including smoking and previous radiotherapy. Hence, risk factors can be considered to be a major reason for complications arising after nasal reconstruction. Since 71.44 % of the patients are males, we can conclude males are more prone to complications following nasal reconstruction surgery than females. There does not seem to be any direct effect of the defect size, depth or site on the complications arising after nasal reconstruction.

LITERATURE

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COMPARATIVE ANALYSIS OF NASAL ALAR RECONSTRUCTION OUTCOMES FOLLOWING USE OF MELOLABIAL FLAP AND JIGSAW PUZZLE FLAP

Introduction

Non-melanoma skin cancer is mainly located on the face, accounting for 75 % of cases; of these, 30–35 % is located in the nose. These tumors are homogeneously distributed in the nose, being more frequent in nasal alar [1, 2]. The treatment is mostly surgical, aiming at complete removal of the lesion with minimal functional and aesthetic damage. Surgical defects located in the nasal alar are challenging to reconstruct since the integrity of this region is very important for maintaining the aesthetics and function of the nose [2, 4]. The melolabial flap is a versatile technique for functional and esthetic rehabilitation of defects. Because of the relative proximity of this donor site to these areas, not only is the color match of the skin excellent but hiding the donor site incision in a natural crease line (that frequently deepens with age) affords excellent camouflage [3, 4]. The melolabial flap has arguably less donor site morbidity and normally does not need to be delayed. But the melolabial flap blood supply is not quite as robust as the forehead sites and must be elevated as atraumatically as possible. For larger defects involving the alar rim or a full-thickness loss, the melolabial flap will generally provide surface area, adequate bulk, and a vascular supply, which will support a cartilage graft [2, 4]. One of the disadvantages is detectable prominence at the base of the flap, which interrupts the relief of