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doi:10.1684/ejd.2020.3933

## DermSurgery: nasolabial transposition flap for reconstruction of two adjacent nasal defects

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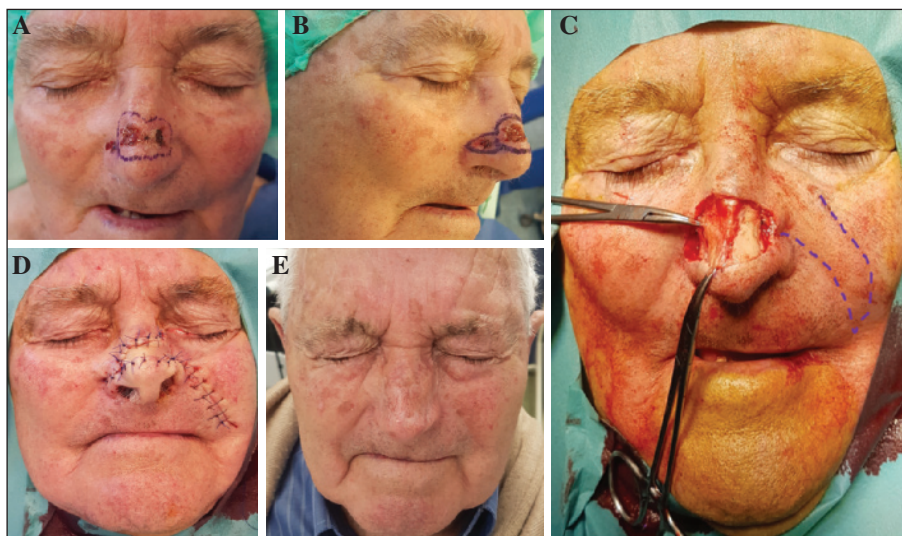
An 88-year-old male patient presented with basal cell carcinoma involving a 23 × 14-mm area on the dorsum of the nose and a second area within 5 mm from the right ala nasi (figure 1A, B). The tumours were surgically removed, result-

ing in two adjacent defects with a total size of 38 × 21 mm (figure 1C). For reconstruction, a nasolabial transposition flap was performed. A year after surgery, no recurrence was noted and outcome was aesthetically favourable (Figures 1D, E).

The nasolabial (also called melolabial) transposition flap has been commonly described and used for facial soft tissue reconstruction since the 19<sup>th</sup> century. However, the first recorded description dates back to as early as 600 BC by Sushruta [1]. This technique allows the use of a flap along the whole length of the nasolabial fold, down to the border of the chin and within the width determined by the amount of natural excess of tissue at the nasolabial crease and its extensibility [2]. Nasolabial flaps have therefore been widely used for reconstruction of defects of areas including the ala, side wall, columella lip and cheek [3-5]. Traditional designs have resulted in significant blunting of the nasofacial sulcus and frequently a trapdoor deformity, often requiring one or more postoperative revisions. In 1990, Zitelli described several modifications of the traditional design that helped to minimize the need for surgical revision [6]. The flap should be designed to include the preplanned excision of the Burow's triangle along the lateral nasal sidewall. The donor site should parallel the nasolabial fold and be widely undermined. Also, the recipient site should be undermined in a submuscular plane on the nose. The first stitch is a periosteal suture placed in the undersurface of the flap, allowing recreation of the nasofacial sulcus and decreasing the tension of the flap.

In our case, a nasolabial transposition flap allowed closure of a wide defect, as a result of two adjacent areas. The pedicle of the flap was wide enough to ensure adequate blood supply. Therefore, we avoided the use of more complex techniques with potentially less favourable outcomes.

In conclusion, the nasolabial flap is a quick and effective approach for closure of defects of the midfacial area. This technique takes advantage of the use of a wide and rich vascularized flap, matching the requirements of complex reconstruction. Due to its versatility and effectiveness,



**Figure 1.** A, B) Basal cell carcinoma involving a 23 × 14-mm area on the dorsum of the nose and a second area within 5 mm from the right ala nasi. C) Resulting defect and design of a transposition nasolabial flap. D) Immediate post-operative result. E) Clinical outcome one year after the surgical procedure.

along with good functional and aesthetic outcomes, the nasolabial flap remains one of the most useful options for reconstruction in the area of the facial triangle. ■

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doi:10.1684/ejd.2020.3934

## Chilblain-like eruption in COVID-19 disease: possible pathogenetic role of temperature

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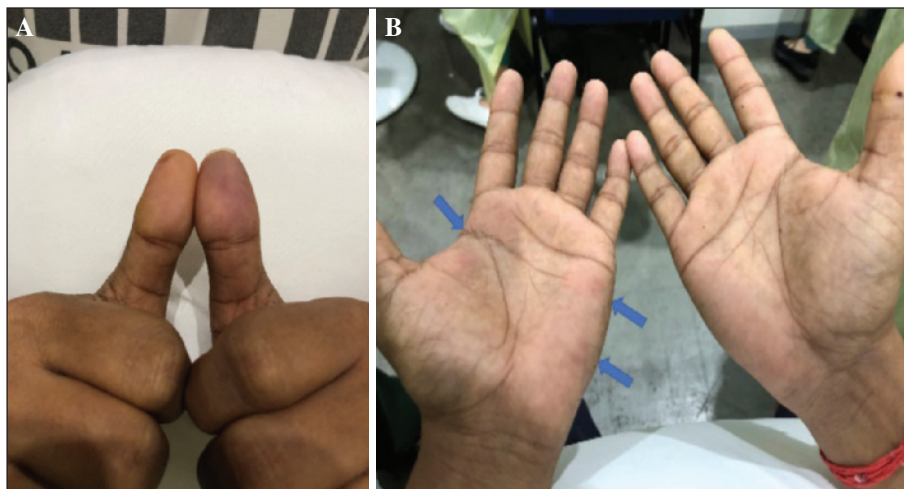
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The coronavirus disease 2019 (COVID-19) is caused by a novel coronavirus, SARS-CoV-2, first isolated in China in 2019. It has been associated with various skin manifestations, comprising maculopapular, urticarial, vesicular eruptions, chilblain-like lesions, and livedo/necrosis [1]. There have been multiple reports [2] of chilblain-like eruption in countries coincident with the COVID-19 pandemic spread, however, the pathogenesis of the eruption remains to be elucidated. Type I interferon and cytokine response to the viral infection have been shown to result in microangiopathic changes and chilblain-like lesions [3].

Chilblains, or pernio, classically present as erythema and swelling of the extremities following cold exposure. Chilblain-like lesions are named as such as they resemble idiopathic chilblains, and the patients typically do not have a history of chilblains or collagen vascular diseases. Reported cases of COVID-19-related chilblain-like lesions have been reported from Europe, the Middle East, and United States [2] during the months of February to May, but none have been reported from tropical regions such as South America or Southeast Asia [4]. A proposed theory is that cold exposure may be a co-factor for the cutaneous inflammation that occurs in chilblain-like lesions.

In Singapore, the temperature is higher than 20°C perennially and idiopathic pernio does not typically occur. Patients with mild COVID-19 disease in Singapore have been isolated in large community facilities and out of 11,000 patients admitted under our care so far, there has only been one patient who presented with chilblain-like lesions. The patient was a 26-year-old Indian male whose nasopharyngeal swab was positive for SARS-CoV-2 based on polymerase chain reaction. He presented with mildly painful erythematous patches over his left thumb and palm on Day 15 of his COVID-19 illness. The patches became purpuric in a mildly reticular configuration the following day, associated with swelling of his left thumb (*figure 1*). His pain score was 1 to 2 out of 10. He was otherwise afebrile and systemically well. Laboratory investigations, comprising full blood count, prothrombin time, d-dimer, C-reactive protein, lactate dehydrogenase, and creatinine levels were normal. He was clinically diagnosed to have chilblain-like lesions related to COVID-19 and was prescribed paracetamol as required. Subsequent follow-up at Day 12 after onset



**Figure 1.** A) Reticular purpuric patch over the left thumb. B) Reticular purpuric patches over left palm.