dissection allows independent tissue movement; however, excess dissection leads to obliteration of form and a scarred appearance. The pars marginalis has a J shape, on sagittal section, that contributes to the pout of the lip.[3] We leave the fine interconnections to the overlying white roll and vermilion intact and emphasize accurate approximation of the J shape on either side of the repair. In addition, given that the pars peripheralis has deep (constrictor) and superficial (retractor) layers,[4,5] we use simple interrupted sutures to try to approximate respective layers.

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Raymond Tse, M.D.
Seattle Children's Hospital
4800 Sand Point Way NE
OB.9.527
Seattle, Wash. 98105
raymond.tse@seattlechildrens.org

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Local Flap for Reconstruction of Nonmelanoma Facial Skin Cancer

Sir:

We read with great interest the article entitled "Surgical Treatment and Reconstruction of Nonmelanoma Facial Skin Cancers" by Dr. Rogers-Vizena et al.[1] In the article, several reconstructive options for facial defects were carefully described by anatomical location.

In facial plastic surgery procedures, it is mandatory to preserve facial aesthetic units and subunits to avoid asymmetry and distortions. To reach this important goal, anatomical boundaries should be respected, with any surgical incision or excision performed within or parallel to the relaxed skin-tension lines. This allows a tension-free cicatrization process and helps to improve the cosmetic result.

One of the most important aesthetic subunits of the face, both cosmetically and functionally, is the upper lip. It extends from the base of the nose superiorly to the nasolabial folds laterally and to the free edge of the vermilion border inferiorly; it is located in the middle of the face and has considerable significance regarding appearance and expression. Wrong reconstruction might result in deformity of the laugh line and will be easily noticed.

In older individuals with excess skin, primary closure is preferred to cover a nonexcessive defect. In younger individuals, in whom there is tightness of the skin or defects that are too large, the closure will be effected through the use of transposition, rotation, island, or even bilobed flaps.

In the article, the authors stated that nasolabial flaps are particularly well suited for subunit reconstruction of the ala and the lateral part of the upper lip; however, the tradeoff is donor-site morbidity. In fact, reconstruction through this type of flap often results in medial cheek and melolabial fold contour asymmetry.[1]

In our experience, we could avoid a poor aesthetic result using a "jigsaw-puzzle" flap. The use of this local flap has already been described for repairing lateral nasal ala defects and for reconstruction of retroauricular surgical defects.[2,3]

To integrate the surgical reconstructive options presented in the article by Dr. Rogers-Vizena et al.,[1] we would like to present a case where we used the jigsaw-puzzle flap to reconstruct a lateral upper lip defect.

The flap was used to repair a defect of the right lateral upper lip after basal cell carcinoma resection. Tumor size was 12 × 12 mm; the lesion was excised, with security margins determined by dermoscopy. The final surgical defect size was 15 × 18 mm. Burow triangles were excised parallel to the nasolabial line, and the flap was transposed medially to cover the defect (Fig. 1). The flap was anchored using 5-0 subcutaneous absorbable sutures, and the final cutaneous closure was performed with running 5-0 nylon sutures.

This flap allowed the use of cheek skin to cover a lateral labial defect with minimal disfiguring of the laugh line, in a single-stage operation. Eight weeks after surgery, this subcutaneous advancement flap provided good functional and aesthetically acceptable reconstruction. With the jigsaw puzzle advancement flap, excess skin and subcutaneous fat from the cheek can be easily moved into lateral upper lip defects, with good functional and aesthetically acceptable results.

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Amgiad Fallaha, M.D.
Franco Perino, M.D.
Klaus Eisendle, M.D.
Department of Dermatology
Hospital of Bolzano
Bolzano, Italy

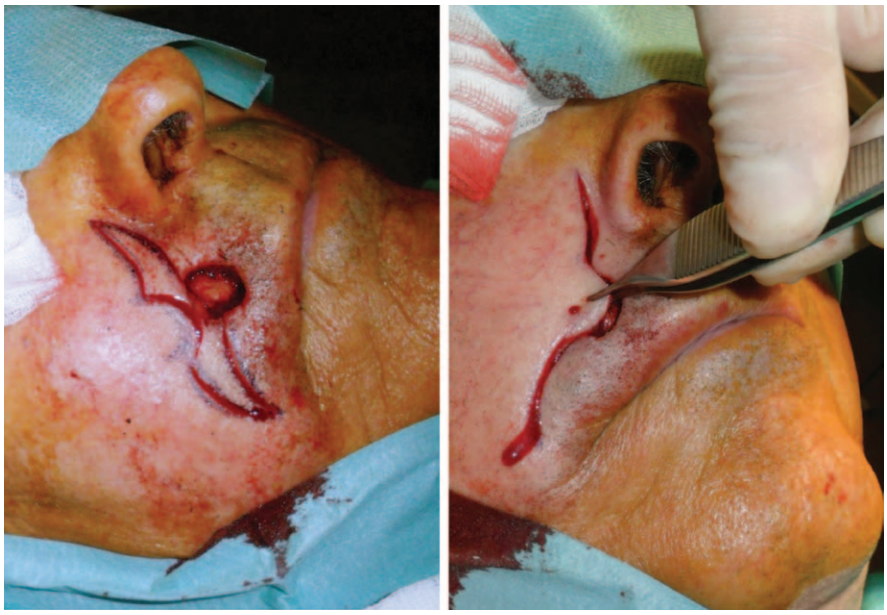

Fig. 1. Jigsaw puzzle advancement flap for reconstruction of the lateral upper lip defect.

Andrea Sisti, M.D.

Juri Tassinari, M.D.
General and Specialist Surgery Department
Plastic Surgery Division
University of Siena
Siena, Italy

Francesco Idone, M.D.
Jalisco Plastic and Reconstructive Institute
University of Guadalajara
Guadalajara, Jalisco, México

Giuseppe Nisi, M.D.
General and Specialist Surgery Department
University of Siena
Siena, Italy

Correspondence to Dr. Sisti
General and Specialist Surgery Department
Plastic Surgery Division
University of Siena
Viale Bracci 16
Siena 53100, Italy
asisti6@gmail.com

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Reply: Surgical Treatment and Reconstruction of Nonmelanoma Facial Skin Cancers

Sir:

We thank Fallaha et al. for their recent letter regarding our CME article, "Surgical Treatment and Reconstruction of Nonmelanoma Facial Skin Cancers." They present a case report of a broadly based advancement flap with the moniker "jigsaw puzzle flap" for reconstruction of small lateral lip defects. Intraoperative photographs demonstrate the design of Burrows triangles flanking the semicircular cheek advancement flap, facilitating its advancement into a lateral lip defect.

Advancement flaps are a mainstay of reconstructive plastic surgery and are often used in our own practices for reconstruction of small defects. The authors emphasize the importance of adherence to the aesthetic unit principle,[1,2] and we echo that sentiment. In our own practices, we most often use advancement flaps in situations where aesthetic units can be respected, or where no better option exists. In that spirit, the jigsaw puzzle flap for lateral lip reconstruction raises two questions. Can the Burrows triangles and advancement flap be designed in a manner that better respects the nasolabial fold? Does the gentle curving incision straighten with time as the scar contracts, better simulating the nasolabial fold? The conundrum of reconstructive plastic surgery is the concept of "robbing Peter to pay Paul," and in the majority of situations there is some tradeoff. Arming oneself with a variety of reconstructive options is a surgeon's best strategy to navigate the variable landscape of facial reconstruction, and the authors have provided another tool.

In our initial article, we described the evidence for basic treatment of common skin cancers and general principles of reconstruction. Given the breadth of this topic, the reviewed reconstructive techniques were limited to one or two local workhorse flaps per region of the face,