Chapter 171
Glabellar Flap

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Indications

The glabellar flap can be used to reconstruct the medial canthus in cases of tumor resection, trauma, or congenital defects. It is best suited for patients with moderate skin laxity and round defects of the medial canthus [1–4].

Essential Steps

1. Mark the skin for the flap.
2. Infiltrate local anesthetic into the medial canthus and glabellar flap.
3. Outline the flap using a #15 Bard-Parker blade.
4. Dissect in the subcutaneous fat layer using Westcott scissors to create the flap.
5. (*Trim the excess skin from the flap*).
6. Secure the flap to the subcutaneous tissues of the medial canthus.
7. Close the skin.
8. Undermine the glabella.
9. Close the subcutaneous tissue of the glabella.
10. Close the skin of the glabella to maximally evert the skin edges.

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Complications

- Infection
- Bleeding/hematoma
- Pain
- Poor cosmesis
- Graft necrosis

Template Operative Dictation

Preoperative diagnosis: (*Right/Left*) medial canthal defect

Procedure: (*Right/Left*) reconstruction of the medial canthus via glabellar flap

Postoperative diagnosis: Same

Indication: The patient is a ___-year-old (*male/female*) who (underwent *Mohs excision of a skin cancer, underwent primary excision of a benign lesion, sustained trauma*) resulting in a medial canthal defect involving skin and muscle. The upper and lower puncta and canaliculi were probed and irrigated, and the lacrimal drainage system was found to be intact. Given the patient's moderate skin laxity and lack of a continuous brow, the decision was made to perform a medial canthal reconstruction using a glabellar flap. The patient was informed of the risks, benefits, indications, and alternatives of the procedure, and informed consent was obtained.

Description of the procedure: The patient was identified in the holding area, and a marking pen was used to mark the (*right/left*) eye. The patient was escorted into the operating suite and placed in the supine position. Tetracaine eye drops were instilled into both eyes. The patient's face was prepped and draped in the usual sterile fashion for oculoplastic surgery. IV sedation was administered by the anesthesia service. A surgical time-out was performed in accordance with hospital policy, verifying the correct patient, procedure, site, positioning of the patient, special equipment, and safety precautions.

An inverted V was marked with a marking pen centered in the midline of the glabellar region with the first arm of the V corresponding in length to the width of the defect and the second arm equal in length and angled 45° to the first arm. The area of the (*right/left*) medial canthus and glabella was infiltrated with a 50/50 mixture of 2% lidocaine and epinephrine 1:100,000 and 0.5% Marcaine for local anesthesia. A corneal protective shield was placed in the eye.

The inverted V flap was created using a #15 Bard-Parker blade. The flap was then elevated in the layer of the subcutaneous fat using Westcott scissors. The flap was rotated into the area of the medial canthus and anchored to the tissues of the medial canthus using several deep, interrupted, buried *5-0 polyglactin* sutures. (*Excess skin was trimmed from the flap using Westcott scissors* .) The flap was noted to cover the

entire medial canthal defect, and there was no tension on the flap. The skin of the flap was sutured into the defect using several interrupted *6-0 polypropylene/plain gut* sutures. The area of the glabella was undermined medially and laterally and then closed using several interrupted subcutaneous *5-0 polyglactin* sutures. The skin of the glabella was closed with running horizontal mattress *5-0 polypropylene* sutures to maximally evert the skin edge and prevent atrophic scarring. The corneal protective shield was then removed.

Following the procedure, antibiotic ophthalmic ointment was placed in the eye, and the patient was escorted to the postoperative care area, where he/she remained for approximately 45 min before being discharged to the care of a responsible adult.

References

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