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CLOSURE OF CENTRALLY LOCATED DEFECTS OF THE EAR

Sir:

I read with interest the short article "Extended Preauricular Skin Flap for Closure of Centrally Located Auricular Defect" (*Plast. Reconstr. Surg.* 101: 538, 1998). My suggestion is that the authors try a postauricular flap based either inferiorly or superiorly and tunnel through the ear itself. This flap is particularly useful for surfacing any defect over the anterior surface of the concha or anterior part of the ear after a basal or squamous cell carcinoma excision.

It's also useful for lining the ear canal with full-thickness, vascularized coverage in cases of ear canal stenosis. The flap from the postauricular fold can be 3:1 or 4:1 at the base, and patients have universally not been aware of any significance in their residual sinus. Closure of the sinus is routinely offered as a secondary procedure, but I have yet to have a patient who has requested it. Sinuses become quite small and inconspicuous, particularly if they are located around the base of the concha or behind the helical fold anteriorly.

This use of the flap was suggested to one of my colleagues who had requested I do full-thickness grafts for ear canal stenosis. He subsequently published a report that apparently was well received. Unfortunately, I received neither a consultation fee nor the acknowledgment!

Using a postauricular flap leaves an inconspicuous donor site and very reliable and predictable full-thickness vascularized coverage from the anterior surface of the ear. It's simpler and faster than doing a full-thickness graft.

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A SIMPLE TECHNIQUE FOR MUCOSAL IRREGULARITIES OF THE LIP

Sir:

I read with interest the communication from Drs. S. T. O'Sullivan and M. O'Shaughnessy of Leeds, England, entitled "A Simple Technique for Correction of Mucosal Irregularities of the Lip" (*Plast. Reconstr. Surg.* 101: 1146, 1998). They show a photograph in which a bone cutter is used to excise excess mucosa of the upper lip. I would like to point out to the readers of the *Journal* the origin of this idea, and I have enclosed a copy of a diagram taken from *Principles and Practice of Plastic Surgery* by Barsky, Kahn, and Simon, which was published in 1964 (Fig. 1). I had the privilege of working with Dr. Barsky, and I saw him use this technique many times.

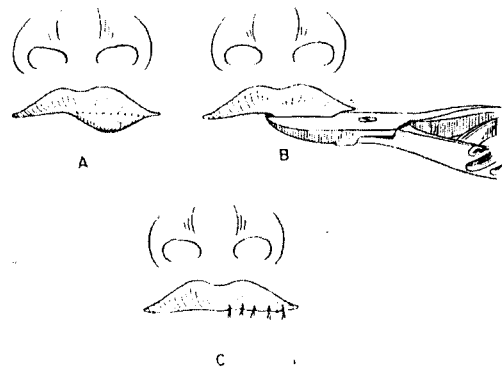


FIG. 1. Secondary procedure for reducing a thickened vermilion border. (A) The dotted line indicates the proposed level of the reduced lip. (B) A straight bone-cutting forceps is applied at the site. These forceps crush but do not cut the soft tissue. The crushing should be maintained for about 5 min. The excess tissue is then removed with a pair of scissors. (C) The closure. This technique has the advantage of being bloodless and avoiding postoperative edema. From Barsky, A. J., Kahn, S., and Simon, B. E. *Principles and Practice of Plastic Surgery*. New York: McGraw-Hill, 1964. P. 362.

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EFFECTS OF THE GENIOHYOID MUSCLE IMPAIRMENT IN TONGUE INJURY WITH MANDIBULAR FRACTURE

Sir:

Buntic and Buncke¹ reported a successful replantation of an amputated tongue (*Plast. Reconstr. Surg.* 101: 1604, 1998). The tracheostomy that was performed might have provided emergency care to the patient for airway protection against free bleeding, edema, or retrusion and deviation toward the posterior direction of the base of the tongue.

Although the severity and permanence of impaired tongue function depend on a number of complex factors, the function of the geniohyoid muscle must be weighed against the risks to upper airway obstruction and difficulty in swallowing, even when edema or bleeding from the tongue is ruled out. The reason is that the geniohyoid muscle, which is innervated by cervical spinal cord motor neurons with the hypoglossal nerve,² elevates the hyoid bone and, therefore, the floor of the mouth and the base of the tongue.³ However, the authors do not refer to this issue. Was there any attempt to ascertain whether the mental spine and the adjacent internal surface of the mandible were injured along with the other alveolar fractures? We do not think that the geniohyoid muscle impairment was associated with a vein graft in the floor of the mouth to the submandibular region. We would like to know whether the tracheostomy lasted for 12 days postoperatively because of the edema or geniohyoid muscle impairment. These possible occurrences should be considered before arriving at any conclusions about the prognosis of their dysfunctions.