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TOPIC 8: SKIN TUMORS OF THE HEAD AND NECK

Prog. no.	Title/Authors
234	SINGLE BENIGN LESIONS OF THE NECK Vukelic-Markovic S, Damjanovic Z, Jovic N, Loncarevic S
235	SKIN TUMORS OF HEAD AND NECK: OUR EXPERIENCE 2001–2003 Maremonti P, Cocchi R, Pederneschi N
236	STUDY OF BASAL CELL CARCINOMA IN PATIENTS OF THE OMF SURGERY CLINIC IN CLUJ-NAPOCA, ROMANIA OVER A PERIOD OF 10 YEARS (1994–2003) Vidiu M
237	ETIOLOGY AND EPIDEMIOLOGY OF NONMELANOMA SKIN CANCER: A REVIEW Mutavdzic A, Videnovic G, Bjelogrljic G
238	COMPARATIVE CLINICAL AND NUCLEAR MORPHOMETRIC ANALYSIS OF SQUAMOUS CELL SKIN CANCER OF THE HEAD AND NECK Kovacevic P, Visnjic M, Mihailovic D, Kovacevic T, Vukelic-Markovic S
239	SUBCLINICAL HORIZONTAL GROWTH OF NON-MELANOMA SKIN CANCERS Videnovic G, Stanisavljevic G, Mutavdzic A, Bjelogrljic G
240	IS IT POSSIBLE TO DIE FROM NON-MELANOMA SKIN CANCER? Virag M
241	SKIN TUMORS OF THE HEAD AND NECK IN ORGAN TRANSPLANT RECIPIENTS Nardini LG, Piaserico S, Alaibac M, Fortina AB, Ferronato G
242	SKIN FACE LESIONS REPAIRED BY RHOMBOID FLAP Karabouta-Voulgaropoulou IR, Tsodoulos SP, Kalimeras EL
243	FACIAL RECONSTRUCTION WITH PREFABRICATED TEMPOROFASCIA FLAP AFTER SKIN CANCER REMOVAL Barthélémy I, Sannajust JP, Mandard I, Beaujard H, Emering C, Revol P, Mondié J-M
244	RECONSTRUCTION OF LARGE LOWER FACE DEFECTS AFTER MALIGNANT TUMORS Mirodot B, Iorgulescu D
245	THE REVERSE HELICAL CHONDRO CUTANEOUS FREE FLAP IN DISTAL NOSE RECONSTRUCTION: TECHNICAL REFINEMENTS, EXTENDED INDICATIONS AND ANATOMICAL LIMITS Dakpe S, Lengele B, Willemart G, Gbaguidi C, Testelin S, Devauchelle B
246	THE SUPERIOR EYELID FLAP IN THE RECONSTRUCTION OF TRANSFIXING INTERNAL CANTHAL INJURIES Lopez R, Lauwers F, Mayorca-Guiliani A, Paoli J-R, Boutault F
247	EYELID RECONSTRUCTION FOLLOWING RESECTION OF MALIGNANT SKIN TUMOR Orsini R, Marchetti E, Cipriani O, Scopelliti D
248	LOCAL FLAPS IN THE RECONSTRUCTION AFTER MALIGNANT TUMORS OF THE SCALP Iorgulescu D, Ibric-Cioranu V, Mirodot B
249	FAMILIAL NEUROFIBROMATOSIS Badalyan Kh, Badalyan A
250	THE ULTRASONOGRAPHICAL TARGET SIGN OF PLEXIFORM NEUROFIBROMAS IN NEUROFIBROMATOSIS TYPE 1 PATIENTS IS RESTRICTED TO THE DISPLACING SUBTYPE Friedrich RE, Mautner V-F, Giese M, Scheuer HA, Kluwe L

SKIN TUMORS OF THE HEAD AND NECK IN ORGAN TRANSPLANT RECIPIENTS

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An increased frequency of neoplastic disorders is a recognized complication of solid organ transplantation. Skin cancers are the most common malignancies occurring in transplant recipients, with an increasing frequency with time after transplantation. Skin cancers are more aggressive with a higher risk of metastasis than in the general population. The large majority of neoplastic lesions develop on the head and neck, suggesting an additive or potentiating immunosuppressive effect exerted by sunlight exposure in transplant recipients that are already on chronic pharmacological immunosuppression. In our experience based on 1200 organ transplant recipients, we found a total of 245 head and neck skin cancers in 127 (10.6%) patients. The presence of head and neck solar keratosis, the precursor of squamous cell carcinomas (SCC), was detected in 350 patients. These pre-neoplastic and neoplastic lesions developed at younger age compared with the general population, were often multiple, and showed atypical clinical features. Since these lesions habitually show increased aggressiveness, with a higher risk of local recurrences, regional and distant metastasis, early intervention represents the key to preventing metastatic disease and death. Precancerous lesions can be treated with cryotherapy, topical 5-fluorouracil, topical immunomodulators and photodynamic therapy. Skin cancers should be managed with surgical excision or, alternatively, with electrodesiccation-curettage, curettage-cryotherapy, photodynamic therapy. Transplant patients who are deemed high risk should receive regular dermatological follow-up visits every 3-6 months, whereas annual examination could be sufficient for the remainder. Skin cancers as well as precancerous lesions should be treated as soon as diagnosed and with the most radical approach possible. The level of immunosuppression should be kept as low as possible, in order to reduce the risk of SCC and Kaposi's sarcoma, consistently with a good graft function. Patients should be advised to avoid sunlight exposure, to use high-factor sunscreens and to wear protective clothing.

Keywords: Skin tumors; Organ transplant

SKIN FACE LESIONS REPAIRED BY RHOMBOID FLAP

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(*t*-test 2.38; *P* < 0.05). The only deviation from this statement can be seen in the first diametrical group (to 10mm) which brings up the conclusion that after the initial growth of skin cancers, further growth stabilizes the values of maximum horizontal subclinical extensions, especially with exofitital type of growth. To attain more than 95.25% of eradication of horizontal sprouts of exofitital type of cancer up to 20 mm in diameter, "surgical margin" of minimum 6mm is recommendable for cancers of 21 to 30 mm and minimum 8mm for those of over 31mm. **Discussion:** The aim of this study is not to present the percentage of recuperation, for which at least five year patient monitoring is necessary, but to enable practitioners who engage in this pathology to predict subclinical tumor extensions so that they can preoperatively determine surgical margins

Keywords: Basal cell carcinoma; Squamous cell carcinoma; Non melanoma skin cancer; Horizontal growth

IS IT POSSIBLE TO DIE FROM NON-MELANOMA SKIN CANCER?

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The treatment of skin cancer is simple and as a rule results in cure. However, the treatment of recurrent or extremely advanced skin cancer is sometimes disappointing. The objective of this study was to identify the patients having a recurrence following initial treatment and among them the rare patients succumbing due to skin cancer. In a 25 year period a total of 123 patients were treated or only evaluated for a non-melanoma skin cancer recurrence. Out of these patients 12 were initially seen at our Department and the remaining 111 patients had a recurrence following initial treatment elsewhere. The treatment of recurrences ranged from a simple reexcision up to major craniofacial resections. Several patients were considered unresectable and received no treatment at all. Eighteen patients were not cured. There were 10 patients with a basal cell cancer, one with a Merkel cell tumor, one with a sebaceous carcinoma, and six with squamous cell cancer. One previously untreated patient with a neglected scalp basal cell cancer invading the brain was considered incurable. Three out of 11 patients with a recurrence following initial treatment at our Department died due to skin cancer. One had perineural spread of a squamous cell cheek cancer to the middle cranial fossa, the second an uncontrolled primary tumor, the remaining patient had metastatic dissemination of a Merkel cell tumor. Fourteen out of 111 patients initially treated elsewhere died or were last seen with a recurrence—12 of them had uncontrolled local disease. Two patients were reported as having distant metastases; none was verified at our Department. Very seldom it is possible to die due to skin cancer. As a rule it is the unusual neglect by the patient or ignorant initial treatment and no follow up that precede.

Keywords: Skin cancer; Recurrences; Non-melanoma skin cancer