Aggressive Mass Excision Through Nasolabial Fold Area in the Treatment of Facial Neurofibromatosis: Case Report

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Background: Neurofibromatosis type 1 is a rare disease which can manifest itself by the development of plexiform neurofibromatosis, with craniofacial deformities. In this paper, we propose special consideration in excision nasolabial fold mass to help lifting procedures in neurofibromatosis patients.

Methods: We are reporting two cases, both presented with von Recklinghausen’s disease, a 21 years old male patient with neurofibromatosis in his right hemifacial for which he had been operated on five times previously at other center, and a 24 years old male with neurofibromatosis in his left hemifacial.

Result: After several stages of reconstruction which started with nasolabial fold mass excision, the result was satisfactory, by using the multiple stage repair, it was done until the end result is similar to anatomical form.

Conclusion: The mass debulking procedures for these patients, which started with Nasolabial Fold mass excision are continued with durable lifting procedures. This method gives results a satisfactory lifting procedure.

Keyword: Neurofibromatosis type I, nasolabial fold mass excision, Von Recklinghausen disease.

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skin properties lead to an inexorable deterioration of functional and cosmetic results.\(^4\)

Surgical treatment for these deformities is difficult, especially in craniofacial area and needs aggressive procedures. Many surgeon prefer multiple serial excisions, as it is almost impossible to remove the entire tumor in one stage of reconstruction. However, because mass debulking are usually not accompanied by durable lift procedures, the skin sags again because of the gravitational effect on the remaining tumor.

We are reporting two case, both presented with von Recklinghausen’s disease, a 21 years old male patient with neurofibromatosis in his right hemifacial for which he had been operated on five times previously at other center, and a 24 years old male with neurofibromatosis in his left hemifacial. In treated neurofibromatosis patient we use multiple stage reconstruction, with special consideration excision on nasolabial fold area which we believe will be very helpful in decreasing mass of the tumor so the skin will not sags again by the time we perform lifting procedure.

**Case 1**

A 21 year old male patient was admitted to Plastic Surgery Department of Cipto Mangunkusumo Hospital with a diagnosis of Von Recklinghausen’s disease, NF type 1 in his right hemifacial region with history of 5 debulking surgery in the past at other center. (See Fig 1 to 6)
A 24 year old Indonesian male was admitted to Plastic Surgery Department of Cipto Mangunkusumo Hospital with a diagnosis of NF type 1 of the left facial region. The massive and enormous tumour involving the inferior region of his left forehead, left eyebrow, left orbit, left temporal region, left auricle, left midfacial region (cheek), left nose, left side of the mouth and lips, left mandibular and sub-mandibular region extending to his chin is confirmed and with an appearance like melting wax from a candle.

Multiple surgeries were necessary in order to remove the patient’s tumor from his body. Each procedure was performed under general anesthesia.

**First stage operation (30/06/09)**

An incision was made at the left neck region alongside with the sternocleidomastoid muscle through cutis and subcutis. Sternocleidomastoid muscle was separated. Identification of commune carotid artery was made and preserved to the proximal, identification of external carotid artery was made, preserved and controlled with "lasso" technique. (see fig 7-9)

**Second stage operation (15/07/09)**

Excision of tumor mass. The left ear is anchored alongside the lateral canthus. The lateral canthus is then anchored to the superolateral peristomeum. Sub-cutis was sewn with 2.0 cutting prolene. Intra dermal was sewn with 4.0 cutting prolene, dermal was sewn with 5.0 cutting prolene.(see fig 10)

**Third stage operation (31/07/09)**

An incision of the left orbital region was made into a flap and the tumor was extirpated. An incision to the superior orbital rim was made and dissected until naso orbital junction was visualized. An anchoring was made on the nasoorbital junction to the left lateral canthus with screw and wire. An incision according to the a’ design was made into a flap and the tumor was excised with skin sparing. On the left nasal region a Cinh suture was made. The left oris commisure was anchored to the zygoma arch with 6.0 cutting prolene. A left eyebrow lifting was done with Treit technique.
with 0 prolene. 3 incision was made at the scalp region, a number 16 abocath was inserted to insert a number 0 prolene, and the eyebrow was then anchored to the periosteum. (see Fig 11)

**Fig 11.** Incision design preoperatively and intraoperative appearance.

**Fourth stage operation (14/08/09)**

Reduction of mass at the parotid, retroauricula, and left buccal region. Intradermal was sewn with 2.0 vicryl dan 3.0 prolene, cutis was stitched with 4.0 prolene. A mass reduction was made at the left supra auricula, there is an attachment of the loose superior helix cartilage, then tied to the periosteum with 1.0 prolene, a skin sparing was done. Intra dermal was sewn with 4.0 vicryl and 4.0 prolene. Cutis was sewn with 4.0 prolene. Mass reduction was made at the left buccal region, 3.0 cromic was used for inner stitching, mucose is stitched with 3.0 cromic. The subtle but noticeable difference in mass size is shown in the serial photo taken after each operations. (see Fig 12)

**Fig 12.** Post operative appearance after each operation.

**DISCUSSION**

Neurofibromas (NF) are benign peripheral nerve sheath tumors composed mainly of Schwann cells and fibroblasts arising from any type of nerve anywhere except in brain or spinal cord, insinuating in normal tissue. Two main types of NF: neurofibromatosis 1 (NF-1) and neurofibromatosis 2 (NF-2). NF-1 in the population (90% of cases), affecting 1 in 4,000 individuals. Onset occurs as early as childhood, and people of all sex, race, and ethnicity are affected equally. The NF-1 gene on chromosome 17, characterized by tumor formations, usually manifest themselves within the peripheral nervous system. Symptoms include Lisch nodules, café-au-lait spots, axillary freckling, numerous fibromas, multiple developmental problems, macrocephaly, optic glioma, hype-tension, short stature, seizures, and distinctive osseus lesions. The severity of each NF-1 case is impossible to predict, and a patient might exhibit all or just a small number of these symptoms.

Plexiform neurofibromas, pathognomonic for NF type 1, is a slow-growing tumor with an unpredictable growth pattern occurs in a variety of locations including skin and subcutaneous tissue, craniofacial region, paraspinal structure, mediastinum, viscera, and retroperitoneum. Rapid growth may occur during early childhood, puberty, or pregnancy, but spontaneous regression does not occur. The incidence ranges from 24.1% (in the National Neurofibromatosis Foundation International Database) to 32 percent of the patients for Huson et al. Facial plexiform neurofibromas usually occur unilaterally and extend from nerves such as trigeminal, facial, or glossopharyngeal ones, insinuate deeply and extensively, making their total removal impossible without sacrificing nontumoral tissues. Surgical treatment is not a complete tumor resection, but a reduction to acceptable cosmetic and functional results.

These patients comes to us with neurofibromatosis type 1. In treated these patients we use multiple stage reconstruction, with special consideration excision on nasolabial fold area which we believe will be very helpful in decreasing mass of the tumor so the skin will not sags again by the time we perform lifting procedure. We adapt this technique based on systematic multiple stage surgical approach using Nagata’s technique in which he modified and utilized the static suspension method with the tensor fascia lata. The surgical approach we use was by doing excision on the corner of the mouth or nasolabial fold area to achieve...
sufficiently wide coverage and large mount of mass because the tumor were extensive hemifacial lesion. To achieve facial symmetry, tensor fasciae latae sling of the mouth corner or nasolabial fold area were performed. By doing this, we hope the tensor fascia lata could minimized further deformity caused by regrowth of the tumor after resection by being a substitute layer of the skin.

The same technique was done in netting operation where the netting of neurofibroma using Teflon mesh as a substitute for the sub-cutaneous layer and a barrier against drooping and minimizing further deformity caused by regrowth after resection, to maintain facial contour and function and to prevent progressive disfigurement. The Teflon mesh is still very expensive and hard to get for most of these patients, so we have not use this technique.

Other approach such as the facial aesthetic unit remodeling monobloc translesional resection technique offered increased predictability in functional and cosmetic results, and allowed us to operate on extensive hemifacial lesions with a lower transfusion risk is still an optional technique that we consider to use in the future.

CONCLUSION

Many procedures of operation with multiple stages reconstruction had to be done for Neurofibromatosis patient during their lifetime. The mass debulking procedures for these patients, which started with Nasolabial Fold mass excision are continued with durable lifting procedures. This method gives results a satisfactory lifting procedure.

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