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Auricular Lobuloplasty - A Case Report

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ABSTRACT:
one of the most aesthetic soft tissue structures in the face is the ear lobule. Ear lobule sagging and clefting is commonly seen in south Indian populations following prolonged wearing of heavy earrings/ trauma. This type of clefting can be complete or partial. Here we report a case of a 20-year-old female patient reported to us with complete clefting of the ear lobule operated with auricular lobuloplasty. There were no postoperative complications and the outcome was satisfactory.

I. INTRODUCTION: -

The facial aesthetics is governed by the harmony between hard and soft tissue structures of the facial skeleton. Ear lobule is an important aesthetic structure which is either round or conical in shape. It is a highly vascularized structure and offers a prime function of bearing the earrings.

Sagging or complete slit in the ear lobule is a prime cosmetic deformity and is a very common occurrence in the Indian populations. This is because of the expansion of the hole/piercing overtime due to the effect of gravity or accidental trauma. Ear lobule clefting can be two types – congenital and acquired.

Congenital cleft earlobe is a rare clinical entity that results from failure of fusion during embryologic development. Congenital defects are usually associated with tissue loss, thereby complicating surgical repair [1]. however, acquired clefts are usually treated as a day care procedure under local anesthesia.

In Africa, the lobules of Ivan and Kayan become wide, sag and tear as they wear heavy and large earrings. [2]. According to American Society for Aesthetic Plastic Surgery in 2015, approximately 40,000 people undergo ear surgery for cosmetic purposes per year for ear defects developing because of trauma or wearing heavy earrings.[3]

Here we report a case of a 20-year-old female patient reported to us with complete clefting of the ear lobule operated with auricular lobuloplasty.

Case report:

A 20-year-old patient visited our clinic with a chief complaint of torn left ear lobule 2 years ago. She gives history of trauma where her earring was forcefully wrenched out of the piercing following which the ear lobule was completely slit.

On clinical examination there was a complete clefting of the ear lobule measuring 1×1CMs in size. (FIG-1). Both the ends of the cleft were fully epithelialized. The patient was medically stable with no systemic conditions including bleeding disorders. We suggested an auricular lobuloplasty for the patient under local anesthesia as the procedure can be performed as a day care procedure on outpatient basis.

Surgical procedure:

Lobuloplasty was performed under local anesthesia. 2% Lignocaine with Adrenaline (1:80000) was infiltrated into the surgical site. Surgical site was disinfected with betadine painting. Marking was done and a 15-number surgical blade was used to incise the ends of the lobular cleft to create a raw surface. (FIG-2). After achieving hemostasis by applying pressure a two layered closure was done using 4-0 vicryl and 4-0 prolene (FIG-3) followed by Betadine-gauze dressing.

The patient was put on Antibiotics and analgesics for 5 days and called back for suture removal after 7 days. The healing was uneventful, and the outcome was satisfactory and aesthetic. (FIG-4).

II. DISCUSSION:

Deformities of the auricular lobule is a common problem necessitating lobuloplasty. Auricular lobule clefts are classified by many ways. Lobule clefts are classified into two groups as congenital clefts and acquired clefts, by Sharma et al,[4] they further divided acquired clefts into two groups such as partial and complete clefts. Based on the distance between the original hole and the lower limit of the lobule Blanko-Davila and Vasconez [5] Classified the partial lobule clefts. Boo-Chai [6] divided the lobule defects into two

groups as congenital and acquired and called the congenital clefts as "coloboma lobuli".

Mc Laren in 1954 first described the closure of lobular defect using simple linear suturing [7]. Following this, many treatment procedures were subsequently proposed by many pioneers. Punch techniques for defects less than 4mm of the lobule were proposed by Tan [8]. Partial defects were first converted into complete defects following which a Z plasty technique was used by Miller and Eisbach where satisfactory results were obtained.[9]

Vujevich et al. [10] deepithelialized the cleft walls and repaired the cleft with a single purse-string suture. Ear lobule is highly vascular and Sandro Cilindro de Souza [11] evaluated the results of torn earlobe repair with simple marginal excision and closure using a tissue adhesive and concluded that the proposed treatment was safe and provided satisfactory results. Viviane Maria Maiolin [12]et al chose a new adapted "L" technique for vertical lobe elongation. They stated that it was a simple technique that presents less chance of recurrence, provides rapid correction of the primary defect and a high probability of patient satisfaction.

The overall satisfaction rate related to the cosmetic results of lobuloplasty has been reported as 92%–100% in most of the studies. The high level of satisfaction can be due to the small surgical field, the simple techniques that can be used to achieve extremely satisfactory results. Complications such as infection, hypertrophic scar, and recurrence of the clefting of the lobule are extremely rare ranging from 0%-33% which makes this procedure further adaptable in the day care practice. [13

In this case, there were no complications with a highly aesthetic result and overall patient satisfaction.

III. CONCLUSION

Auricular lobuloplasty is an extremely safe and easy procedure that can be performed as a day care treatment procedure under local anesthesia. This procedure has low rate of complications and provides good esthetic results.

Conflicts of interest: None

REFERENCES:

1) Tanley, Sharon S. MD; Thaller, Seth R. MD, DMD. Congenital Cleft Earlobe: Technique for Repair of a Triple-Lobe Type Defect. Journal of Craniofacial Surgery: November 2018 - Volume 29 - Issue 8 - p 2310-2311 Doi: 10.1097/SCS.0000000000004788.
2) Niamtu J. Eleven pearls for cosmetic earlobe repair. Dermatol Surg 2002;28(2):180-5.
3) cosmetic Surgery National Data Bank: Statistics, 2015. The American Society for Aesthetic Plastic Surgery website. [Accessed April 1, 2016]. http://www.surgery.org/media/statistics.
4) Sharma R, Krishna S, Kumar S, Verma M. Rotation flap lobuloplasty: technique and experience with 24 partially torn earlobes. Int J Oral MaxillofacSurg.2014;43:120610. https://doi.org/10.1016/j.ijom.2014.04.009. [PubMed] [Google Scholar]
5) Blanco-Davila F, Vasconez HC. The cleft earlobe: a review of methods of treatment. Ann Plast Surg. 1994; 33:67780. https://doi.org/10.1097/00000637-199412000-00023. [PubMed] [Google Scholar]
6) Boo-Chai K. The cleft ear lobe. Plast Reconstr Surg. 1961; 28:681–8. https://doi.org/10.1097/00006534-196112000-00007. [PubMed] [Google Scholar]
7) McLaren L. Cleft ear lobes: a hazard of wearing earrings. Br J Plast Surg. 1954; 7:162–5. https://doi.org/10.1016/S0007-1226(54)80019-1. [PubMed] [Google Scholar]
8) Tan EC. Punch technique—an alternative approach to the repair of pierced earlobe deformities. J Dermatol Surg Oncol. 1989; 15:270–2. https://doi.org/10.1111/j.1524-4725.1989.tb03159.x. [PubMed] [Google Scholar]
9) Miller TR, Eisbach KJ. Repair of enlarged pierced-ear openings. Ear Nose Throat J. 2005; 84:276–7. [PubMed] [Google Scholar]
10) Vujevich J, Goldberg LH, Obagi S. Repair of partial and complete earlobe clefts: a review of 21 methods. J Drugs Dermatol. 2007; 6:695–9. [PubMed] [Google Scholar]
11) Souza SC. Lobuloplasty Torn earlobe repair. Rev. Bras. Cir. Plást.2016;31(3):362-367
12) Maiolini VM, Sbroglio LL, Marques RB, da Silva RT, D'Elia ML. Proposal of a new surgical technique to repair gauge earlobe defect. [Google Scholar]
13) Altıntaş A, Çelik M, Yeğin Y, Kayabaşoğlu G. Auricular Lobuloplasty. Turk Arch Otorhinolaryngol. 2017 Dec;55(4):172-176. doi: 10.5152/tao.2017.2675. Epub 2017 Dec 1. PMID: 29515930; PMCID: PMC5839526.

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Figures:

Figure :1 – Clinical Picture of the lobular cleft

Figure :2 – Deepithelialisation of the cleft walls and creation of a raw defect

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Figure : 3 – Bilayered closure of the defect using 4-0 vicryl and 4-0 prolene

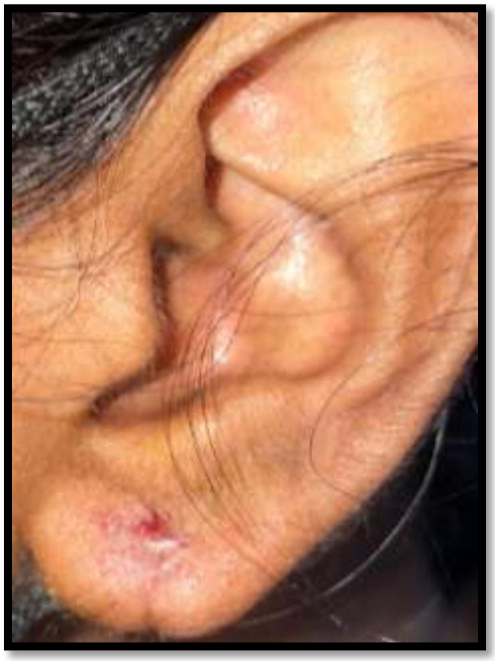

Figure : 4 – one week post-operative follow up – clinical picture showing satisfactory results