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Masseter Flap in Primary Reconstruction of Posterior Oral Cavity – A Case Report

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ABSTRACT
The use of masseter flap for tissue repairing following tumour ablation of posterior part of oral cavity is very demanding. Reconstructive method such as masseter flap can be reliable and effective solution for oral reconstruction .This case report is a transposition of squamous cell carcinoma andan excellent functional result with satisfactory cosmetic appearance. The main advantage of this procedure is that it does not require extensive technique or post-operative care.
KEYWORDS:masseter,tumour,reconstruction,muscle

I. INTRODUCTION

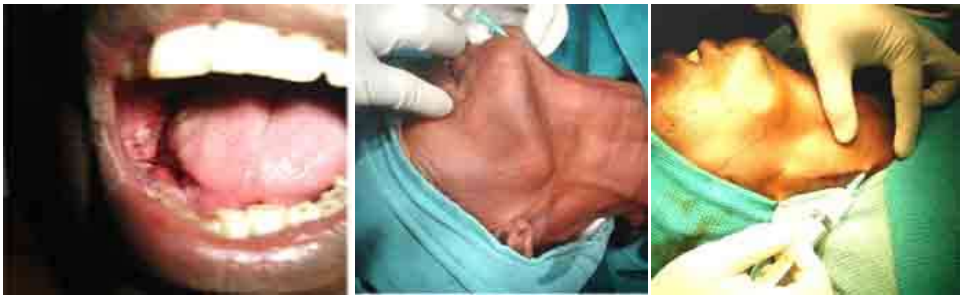
The masseter flap was described by Conley and Gullane in the year 1978. In 1987, Wari described the use of masseter muscle. Carcinoma of the oral cavity in the posterior and inferior region poses a challenge for reconstruction due to the lack of muscle. Masseter flap has an advantage of being a single stage procedure which does not require extensive technique. It provides adequate bulk of the tissue for reconstructing the post-operative defect.

ANATOMY

Masseter muscle is one of the muscles of mastication. It is a powerful superficial quadrangular muscle. This muscle consists of three overlapping heads-superficial, middle and deep. The muscle originates from zygomatic arch and inserts the lateral surface of the mandibular angle, ramus and coronoid. The main blood supply to masseter is massetric artery and the nerve supply is mandibular nerve.

II. CASE REPORT

A75yearold man reported with a ulceroproliferative lesion present in the right gingivobuccal sulcus and an enlargement of submandibular lymph node on the right side. But there is no evidence of fixation or metastasis. An incisional biopsy was carried out and the histopathology of well- defined squamous cell carcinoma was obtained. right side supra omohyoid neck dissection was carried out through apron incision extending to include lower lateral lip split. Masseter muscle is raised and separated from lateral surface of mandible. Marginal mandibulectomy is carried out from rightlateral incisor and along with the tumour tissue. The masseter muscle was brought forward medially and was sutured to the residual part of the mylohyoid muscle. The floor of the mouth was sutured to the medial aspect of masseter muscle and the skin flap was repositioned and layer by layer closure was done.



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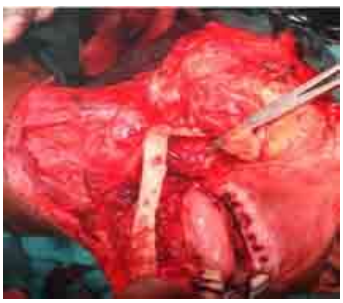
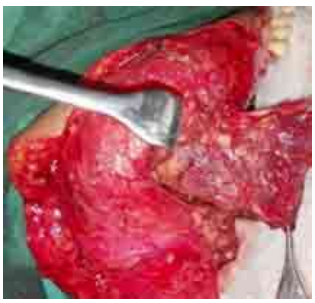
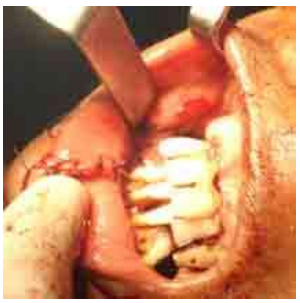

III. DISCUSSION

Post Ablation defects of posterior-inferior part of the oral cavity which are small and moderate in size resulting from a surgery of tumour in oral cavity is presently a challenge to a surgeon while planning for reconstruction. The main objective of reconstruction after ablative surgery in cancer patients is to restore optimum function and aesthetics following all three fundamentals of reconstruction as started by Wilson in 1981. Several methods of reconstruction has been recommended in the literature including skin graft and true tissue transfer. Masseter flap produces adequate bulk for filling the defect following ablation. It is a one stage procedure which does not require extensive dissection or result in functional loss. The cosmetic outcome of the flap is acceptable.The disadvantageof the masseter flap is it's close proximity to the primary tumour

IV. CONCLUSION

Masseter flap is a reliable method for reconstruction of carcinoma cases. Patients capitulate good functional and acceptable cosmesis with normal post-operative complications.

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