



Expose Tibia Coverage Options

Ajay Kumar Pathak^{1*}, Pragati Awasthi² and Akash Jaiswal³

¹Department of Plastic Surgery, Institute of Post Graduate Medical Education and Research, SSKM Hospital, Kolkata, West Bengal, India

²Department of Obstetrics & Gynecology, Institute of Post Graduate Medical Education and Research, SSKM Hospital, Kolkata, West Bengal, India

³Department of Medicine, J K Medical College, Bhopal, Madhya Pradesh, India

*Corresponding e-mail: docmail.1312@gmail.com

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ABSTRACT

Background: Among the most widely used techniques direct closure, skin grafting, local flaps, pedicled flap, and free flap are worthy of note. The reconstruction of traumatic soft tissue defects in the distal third of the leg is one of the most challenging problems in lower limb surgery. Usually, the low mobility of the surrounding skin does not make a direct closure possible. **Aim:** Different surgical options in the management of lower third leg defects. **Material and method:** The study was conducted in the Department of Plastic & Reconstructive Surgery Institute of Post Graduate Medical Education and Research (IPGME & R) and SSKM Hospital, Kolkata from January 2018 to December 2019. **Result:** Several patients were admitted to the Department of Plastic & Reconstructive Surgery and referred patients from the Department of General Surgery and Orthopaedic Surgery, IPGME & R, and SSKM Hospital, Kolkata. From these patients, we have taken 70 patients in which 30 (42.9%) patients were female and 40 (57.1%) patients were male. The mean age (mean \pm S.D.) of patients was 38.2286 ± 18.4651 years. **Conclusion:** Fasciocutaneous flaps may represent a good alternative to the free flaps in areas where other local reconstructive procedures are not possible.

Keywords: Lower third leg, Lower limb, Skin grafting, Local flaps

INTRODUCTION

The common etiological causes are trauma, tumor resection, and chronic infection. The surgical correction of lower third leg defect varies from skin grafting, secondary suturing, local, pedicle flaps to free micro-vascular tissue transfer. The exposed lower third of the leg is a common cause of non-ambulation in the majority of patients. It can also lead to osteomyelitis, sepsis, vascular injuries, etc. Each procedure has its own merits and demerits. By which we can reduce further complications and improve quality of life.

The reconstruction of traumatic soft tissue defects in the distal third of the leg is one of the most challenging problems in lower limb surgery. Among the most widely used techniques direct closure, skin grafting, local flaps, pedicled flap, and free flap are worthy of note. Usually, the low mobility of the surrounding skin does not make a direct closure possible. However, the wound edge approximation shows a high percentage of failure or requires a long time to achieve complete healing [1]. Skin graft compared to wound edge juxtaposition shows an advantage in success rate and in healing time [1]. However, for major defects, a skin graft does not provide optimal coverage of the underlying structures (vessels, nerves, and tendons). Even the coverage with flaps shows some disadvantages. A random flap has an indistinct perfusion pattern that requires a careful assessment of the length-to-width ratio to ensure viability. These

features make random flaps difficult to perform in the lower leg and anyway associated with a high rate of necrosis [2]. Musculocutaneous flaps are widespread in leg reconstruction for their reliability. However, these flaps have few indications in the distal third of the leg due to the impossibility to reach the site of injury [3]. Local fasciocutaneous flaps can be harvested without a careful assessment of the length-to-width ratio but still, show a considerable necrosis rate in the lower third of the leg [4]. Local perforator flaps and free flaps are good options in the reconstruction of traumatic defects of the lower third of the leg. Local perforator flaps have similar perfusion to musculocutaneous flaps but save the underlying fascia and muscles, resulting in less postoperative morbidity of the donor site. In this type of flap, the main risk is related to vascular complications associated with pedicle torsion and deformation. To reduce this risk, it is necessary to identify a perforator with at least 1 mm in diameter [5]. Before or during surgery, the handheld Doppler probe and the colour doppler are reliable techniques to determine the size of the perforator [6,7]. As free flaps, local perforator flaps require a microsurgical procedure but micro anastomosis is not needed. Therefore, these flaps have a shorter operating time compared to free flaps. Free flaps require more operating time, special equipment, and adequate training. In addition, Melissinos and Parks reported that the success rate of the free flap was only 95.6% in the reconstruction of defects of lower extremities (*versus* 96.8%, 100%, and 98.8% of head and neck, trunk, and upper extremities reconstruction, respectively) [8].

MATERIALS AND METHODS

Patients were admitted to the Department of Plastic and Reconstructive Surgery and referred patients from the Department of General Surgery and Orthopedic Surgery, IPGME & R, and SSKM Hospital, Kolkata. The study was conducted from January 2018 to December 2019.

Inclusion Criteria

Any patient of lower third leg defect admitted to hospital.

Exclusion Criteria

Patient of lower third leg defect with

- Polytrauma with other life-threatening injuries
- Collagen vascular disease
- Immunocompromised patients
- Advanced chronic osteomyelitis where amputation is required

Study Technique

Each patient was subjected to detailed history and clinical examination, supplemented by investigative modalities. The treatment was proceeding according to the prevalent standard of care within the facilities available at the hospital, and findings were noted in detail in a systematic way as per the proforma. The patients would be asked the questionnaires at the aforementioned intervals.

RESULTS AND DISCUSSION

70 patients were admitted to the Department of Plastic and Reconstructive Surgery and referred patients from the Department of General Surgery and Orthopaedic Surgery, IPGME & R, and SSKM Hospital, Kolkata. We found that 30 (42.9%) patients were female and 40 (57.1%) patients were male. The mean age (mean \pm S.D.) of patients was 38.2286 ± 18.4651 years.

Gad SS, et al. found that the study included 20 patients-15 males and five females, and their ages ranged between 22 and 65 years [7].

Gopalan G, et al. found that the most common cause for traumatic leg and foot defects are road traffic accidents followed by accidental falls and others, most commonly in males amounting 73%, children 10% and females 17%,

among the skin and soft tissue defects upper and lower 1/3 leg defects are predominant. Among the soft tissue, coverage split-thickness skin graft dominating about 60% of cases, flaps 30% of cases, among the flaps 70% are fasciocutaneous flaps predominantly inferiorly based and 30% are muscle and musculocutaneous flaps, among the muscle predominantly soleus muscle flap was used to cover the defect [8].

Macedo JL, et al. found a mean age of 25.6 years, predominantly male (62.5%). The most frequent wounds were of the distal third of the lower limb (37.5%). Bone or tendon exposures occurred in 55% had and there was a 35% rate of exposed lower limb fractures. The treatments employed were skin grafting (57.5%), local fasciocutaneous flap (15%), muscle flap (12.5%), cross-leg fasciocutaneous flap, reverse sural flap (12.5%), and microsurgical flap (2.5%). The short-term evaluation showed that 35 patients had excellent or good results (87.5%), four had a regular result (10%), and one had an unsatisfactory result (2.5%). In the long term, of the 18 patients who answered the questionnaire, ten resumed walking, even with support, in the first three months after surgery (55.6%) [9].

It was found that 2 (2.9%) patients had Ankle defects, 3 (4.3%) patients had Avulsion injury Leg, 2 (2.9%) patients had Contracture ankle, 7 (10.0%) patients had Degloving injury leg, 1 (1.4%) patient had Degloving injury over lateral malleolus, 5 (7.1%) patients had Expose calcaneum, 1 (1.4%) patient had exposed medial malleolus, 8 (11.4%) patients had exposed tendoachilis region, 18 (25.7%) patients had exposed tibia, 2 (2.9%) patients had exposed tibial implant, 1 (1.4%) patient had heel growth, 2 (2.9%) patients had a non-healing ulcer, 1 (1.4%) patient had squamous cell carcinoma leg and 17 (24.3%) patients had ulcer over heel.

Mendieta M, et al. found that the propeller flaps were based on a single perforator, from the posterior tibial artery in 50%, anterior tibial artery in 39.3%, and peroneal artery in 10.7% of the cases [10]. Complications occurred in 14% of the propeller flaps performed, with 3 partial necrosis of less than 15% of the flap transposed. Complications of the patients occurred in both sex groups; however, for the female group, there was a 75% of complications with a tendency toward the statistical significance of $p=0.038$. The donor site of the flap was closed primarily in 85.7% (24) of the cases. In our opinion, the availability and safety of local propeller flaps justify its use in cases where microsurgical techniques are not an option for the reconstruction of the middle and distal extremity, in small-to-medium defects of soft-tissue coverage of the lower limb.

It was found that 2 (2.9%) patients had an animal bite, 3 (4.3%) patients were diabetic, 7 (10.0%) patients were infective, 2 (2.9%) patients had malignancy, 4 (5.7%) patients had post-burn and 52 (74.3%) patients were traumatic. 20 (28.6%) patients had surrounding soft tissue induration. We found that 15 (21.4%) patients had skin grafting and 1 (1.4%) patient had secondary closure. It was found that 1 (1.4%) patients had advancement flap, 5 (7.1%) patients had bipedicle and 7 (10.0%) patients had transposition.

El-Sabbagh AH, et al. found the reconstructive procedures applied five flaps, respectively distally based posterior tibial artery perforator flap (n=8), distally based peroneal artery perforator flap (n=4), distally based sural flap (n=6), medial plantar artery flap (n=2) and cross leg flaps (n=6) [4]. In all cases, there were no signs of osteomyelitis of underlying bones or discharge from the undersurface of the flaps. Fat necrosis occurred at the distal end of the posterior tibial artery perforator flap in one female patient. The two cases of medial plantar artery flap showed excellent healing with the closure of the donor site primarily. One cross-leg flap had distal necrosis. Would the lower third of the leg be efficiently covered by posterior tibial, peroneal artery, and sural flaps. 4 (12.9%) patients had lateral supra malleolar flap with skin grafting, 5 (16.1%) patients had Medial plantar artery based flap with skin grafting, 5 (16.1%) patients had Peroneal artery perforator based flap with skin grafting, 1 (3.2%) patient had Peronious brevis muscle flap with skin grafting, 4 (12.9%) patients had posterior tibial artery perforator based flap with skin grafting and 12 (38.7%) patients had Reverse sural fasciocutaneous flap with skin grafting.

Mahesh SG, et al. found that the most commonly performed procedure was muscle flap (45%), followed by a perforator-based fasciocutaneous flap (25%) [11]. No major complications were observed in the post-operative period. Various types of flap cover were adopted to cover the lower-third of leg defects, depending on the nature of the wound. That study delineated that muscle flaps-particularly the reverse hemisoleus flap, are an ideal flap for the lower third of leg defects with fracture site exposed and wound infected. Local muscle flaps have the advantage of being single-staged, faster to perform, and technically easier, compared to free flaps, which have long been considered the gold standard.

We found that 30 (42.9%) patients had Perforator flap/Fasciocutaneous, 1 (1.4%) patient had muscle flap.

In Free Microvascular Tissue Transfer, 4 (44.4%) patients had anterolateral thigh fasciocutaneous free flap with skin grafting, 1 (11.1%) patient had free gracilis muscle transfer with skin grafting and 4 (44.4%) patients had free latissimus dorsi musculocutaneous flap.

Gad SS, et al. found that all defects were covered by the distally based hemigastrocnemius muscle flap [7]. Early complications included graft rejection in two (10%) patients, partial flap necrosis in two (10%) patients, wound infection in one (5%) patient, postoperative hematoma in one (5%) patient, and delayed graft take in one (5%) patient. Late results during follow-up showed one (5%) patient with the hypertrophic scar of the donor area and one (5%) patient with hyperkeratosis. We found that 4 (5.7%) patients had Edema and 5 (7.1%) patients had Edema, seroma. 8 (11.4%) patients had Partial Flap Loss and 6 (8.6%) patients had total flap loss. It was found that 9 (12.9%) patients had Wound Dehiscence, 21 (30.0%) patients had Graft Loss, 10 (14.3%) patients had wound sepsis, 4 (5.7%) patients had Hypertrophic scar and 1 (1.4%) patient had Seroma.

Kumar PS, et al. found that the indication for flap cover was exposed tibia (71%), followed by exposed tendon 21% and exposed implant 8%. The most commonly performed procedure is the inferiorly based fasciocutaneous flaps (45%) followed by reverse fasciocutaneous flaps (32%) [12]. Edema and infection were the common complications encountered 23% and 18%, respectively. 70% of patients graded the reconstruction as good, 23% as fair, and 7% as poor. Fasciocutaneous flaps may represent a good alternative to the free flaps in areas where other local reconstructive procedures are not possible.

Mofikoya BO, et al. found that perforator-based fasciocutaneous flaps were the most commonly used (48%;12), while muscle flaps (24%;6) and adipofascial turnover flaps (20%;5) were less utilized [13]. Two patients died and one underwent a below-knee amputation. Late infection persisted in 16% (4) of the patients seen.

Franken JM, et al. found that thirty-five patients (67%) have been treated because of posttraumatic soft-tissue defects and, therefore, insufficient fracture coverage [5]. Seventeen patients (33%) were treated because of chronic osteomyelitis that arose after the trauma. In our study, we did not find a statistically significant difference between the postoperative complications of local and free flaps. A significant increase could be demonstrated in the number of revisions after treatment with a free flap. Treatment with a fasciocutaneous flap in the entire study group was associated with significantly more postoperative complications than treatment with a musculocutaneous flap. There was no significant difference in results after early or late flap coverage. Patients treated with local or free flaps achieved equal outcomes, except for the number of postoperative revisions in which local flaps required lesser revisions. Treatment with a musculocutaneous flap is preferable to treatment with a fasciocutaneous flap regarding postoperative complications. The timing of operation proved not to be a discriminating factor.

In the secondary procedure, 1 (3.8%) patient had bone drilling, dressing, 1 (3.8%) patient had debridement, margin positive, resection, skin grafting, 2 (7.7%) patients had delayed tendon reconstruction, 1 (3.8%) patient had dressing, debridement, grafting and delayed tendon reconstruction, 13 (50.0%) patients had dressing, debridement, skin grafting, 1 (3.8%) patient had dressing, debridement and transposition flap with a skin graft, 1 (3.8%) patient had dressing, healing by secondary intension, 2 (7.7%) patients had nerve reconstruction (nerve graft), 2 (7.7%) patients had silicon gel sheath, pressure garment, 2 (7.7%) patients had tendon reconstruction.

We found that 8 (11.4%) patients had good cosmesis, 36 (51.4%) patients had average cosmesis, and 26 (37.1%) patients had poor cosmesis. 26 (37.1%) patients had a good outcome, 24 (34.3%) patients had a fair outcome and 20

(28.6%) patients had poor outcomes. It was found that 17 (24.3%) patients had gait disturbed, physiotherapy advised, 5 (7.1%) patients had gait disturbed, walked with support, physiotherapy advised, 36 (51.4%) patient can walk, 2 (2.9%) patients had Planter flexion, the patient can walk, physiotherapy advised and 10 (14.3%) patients can walk with support (Table 1).

Table 1 Distribution of Diagnosis, Hematoma /Seroma/Edema, Wound Dehiscence, Graft Loss, Wound sepsis and Cosmesis

		Frequency	Percent
Diagnosis	Ankle defect	2	2.90%
	Avulsion injury Leg	3	4.30%
	Contracture ankle	2	2.90%
	Degloving injury leg	7	10.00%
	Degloving injury over the lateral malleolus	1	1.40%
	Expose calcaneum	5	7.10%
	Expose medial malleolus	1	1.40%
	Exposed tendoachilis region	8	11.40%
	Exposed tibia	18	25.70%
	Exposed tibial implant	2	2.90%
	Heel growth	1	1.40%
	Non-healing ulcer	2	2.90%
	Squamous cell carcinoma leg	1	1.40%
	Ulcer over heel	17	24.30%
	Total	70	100.00%
Hematoma/Seroma/Edema	Edema	4	5.70%
	Edema,seroma	5	7.10%
	No	61	87.10%
	Total	70	100.00%
Wound Dehiscence	No	61	87.10%
	Yes	9	12.90%
	Total	70	100.00%
Graft Loss	No	49	70.00%
	Yes	21	30.00%
	Total	70	100.00%
Wound sepsis	No	60	85.70%
	Yes	10	14.30%
	Total	70	100.00%
Cosmesis	Good	8	11.40%
	Average	36	51.40%
	Poor	26	37.10%
	Total	70	100.00%

CONCLUSION

Based on the results obtained in my study, we consider that perforator propeller flaps are ideal in reconstructing

small-medium defects of the middle and distal third of the leg, being safe, easy to perform, providing similar tissue in texture and thickness of damaged tissues, with low donor-site morbidity. Various types of flap cover were adopted to cover the lower-third of leg defects, depending on the nature of the wound in the repair of a defect according to reconstructive ladder (Skin grafting, Secondary suturing, Local flap, Pedicled flap, and Microvascular reconstruction) Fasciocutaneous flaps may represent a good alternative to the free flaps in the areas where other local reconstructive procedures are not possible.

DECLARATIONS

Conflict of Interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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