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UPPER LIP CARCINOMA IN A CHILD

R.B. AHUJA AND R.K. SANDHIR

SUMMARY

A case of carcinoma of the upper lip in a child is reported. Reconstruction of the upper lip in such situations is also discussed briefly.

Carcinoma of lip is the most common malignant tumour of the oral cavity (Cruse and Radocha, 1987; Baker and Krause, 1980; Molnar et al., 1974), yet squamous cell carcinoma arising in the upper lip is a rarity and never before has it been reported in a child. As a corollary, reconstruction of such defects in children have also not been documented previously.

Case Report

An 11 yr. old boy presented with a rapidly growing and fungating lesion of the upper lip (Fig. 1). The lesion (4.5 cm. in size) involved 2/3 of the upper lip, more towards the right side. Two or three lymphnodes palpable in the submaxillary region were firm and discrete. Histologically, it was reported differentiated squamous cell carcinoma.

The lesion was excised with 0.75-1 cm. margin and a right supraomohyoid neck dissection was carried out simultaneously (Fig. 2). The resultant defect in the lip was reconstructed with a free radial forearm flap from the left forearm (Fig. 3), folded along the axis of the vessels. The size of the flap and a low origin of the radial artery made the pedicle short in length. It necessitated interposition of a couple of three inch long vein grafts, taken from the forearm, to bridge the vessels. The vessels were anastomosed to the right facial artery and the right anterior jugular vein. All the four anastomoses were done with 9-0 Ethilon, using loupes with 5 x magnification.

Biopsy report on the dissected lymphnodes was negative.

Six weeks later the flap was slightly thinned and adjusted. At one year follow up the patient was recurrence free and attending school (Fig. 4).

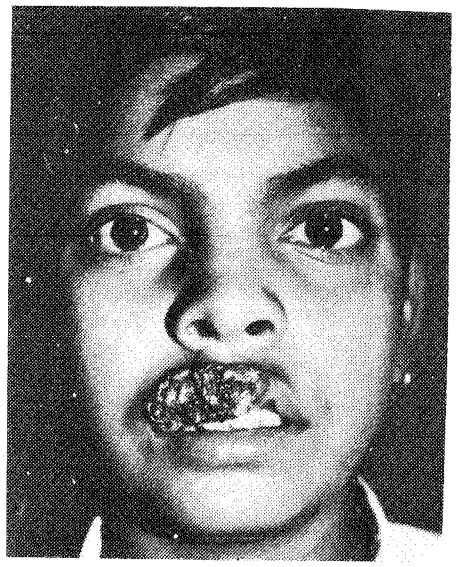

Fig. 1. An 11 year old boy with poorly differentiated squamous cell carcinoma of the upper lip.

Fig. 2. Showing the upper lip defect after excision and neck dissection.

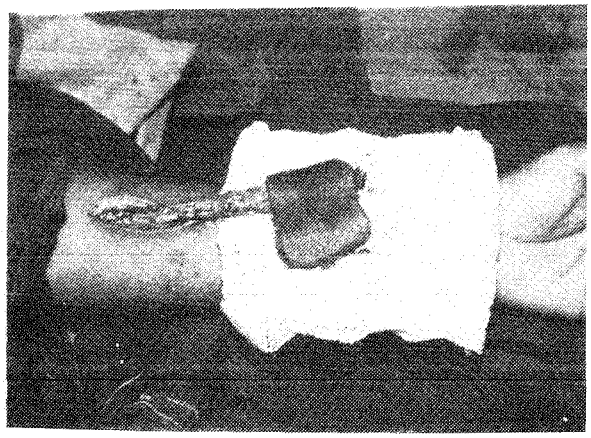

Fig. 3. The left radial forearm flap used in reconstruction after folding it along the axis of the vessels.

Fig. 4. Showing the final result at ten months follow up.

Discussion

Lip cancer is a disease of advanced age. In all the major series reported on the subject the median age of involvement has been 55 to 65 years (Cruse and Radocha, 1987; Guo-Qiang et al., 1987, Baker and krause, 1980; Molner et al., 1974). Of the tumours reported in these series, only six to eight have been on the upper lip. Never before has an upper lip malignancy been reported in a child. The rarity of the disease is also evident from the fact that two series from well known centres (McGregor and Rennie, 1987; Carinol & Fried, 1982), presenting a ten years or more review on Intra-oral/Head and neck malignancy under 40 years of age, do not have a single case of lip cancer.

We feel, such a situation also needs to be documented from the point of view of treatment and reconstruction. Whereas surgery or radiation therapy are equally effective in the treatment of small carcinomas of the lip, in advanced lesions surgery or a combination of surgery and radiation are preferred (Baker and Krause, 1980). Surgical excision also has the advantage of tumour margin assessment and avoidance of radiotherapy complications. Reconstruction of the lip following extensive excisions can be done either by local flaps or by distant tissue. Major lip reconstructions with local flaps is only possible in elderly patients. Even then, these techniques lead to flattening of the lip and microstomia. In children, because of absence of skin laxity and the wrinkle lines to camouflage the scar, it is mandatory to employ distant tissue. Reconstruction with a folded radial forearm flap gives good results in such patients. The tissue and function are restored in a single stage. An intact lower lip provides the lip seal. Whereas provision of animation is essential in lower lip reconstructions by distant tissue (Sawhney, 1986), it is not necessary in upper lip reconstructions. Thus, radial forearm flap is truely a versatile flap for intra-oral reconstruction (Soutar et al., 1983) and it can also be used for lip reconstruction.

Tumorous metastasis from the upper lip malignancies may extend to preauricular nodes, to sub-maxillary region, or directly to the cervical region (Molnar et al., 1974). As chances of occult metastasis in the neck are high in these cases it is recommended to do a prophylactic neck dissection (Wilson and Walker, 1981). In general, for lip carcinoma, a suprahyoid neck dissection is recommended for a primary lesion greater than two centimeter, a poorly differentiated histologic grade, a commissure lesion, a tumour recurrence, a palpable node or a poor patient follow up (Cruse

and Radocha, 1987).

Conclusion

A rare case of squamous cell Carcinoma of the upper lip in a eleven year old child was successfully treated by a free radial artery forearm flap, alongwith suprahyoid block dissection. The child has been followed up for a year and is having no problems.

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The Authors

DR. RAJEEV B. AHUJA, M.S., M.Ch., D.N.B. (Plastic Surgery), *Plastic Surgeon*, Loknayak Jaiprakash Narain Hospital, New Dilhi-110002.

DR. RAKESH K. SANDHIR, M.S., M.Ch., *Senior Medical Officer*, Dept. of plastic Surgery, L.N.J.P.N. Hospital, New Delhi-110002.

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DR. RAJEEV B. AHUJA, B-18, Swasthya Vihar, Vikas Marg, New Delhi-110092, INDIA.