

Pericranial flap

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Indications

Anterior cranial base reconstruction is occasionally necessary following severe **trauma**. Several methods for **reconstruction** have been described and some authors have described their experiences regarding the use of a **pericranial flap** for **anterior cranial base reconstruction** after trauma.

In **1981**, Price et al., first reported the use of the pericranial **flap** for support of the brain following resection of the **anterior skull base**. Since the initial report, considerable experience has been gained with this flap.

It is deployed via a **bifrontal craniotomy** and is placed primarily as a support beneath the **frontal lobes**. The pericranial flap may also be used to repair dural **laceration** and defects. The sinonasal surface is routinely grafted with split-thickness skin or dermis. This technique provides an excellent barrier between the sinonasal cavity and the **cerebrospinal fluid**, establishing a tough, fibrous platform. Herniation of intracranial contents has not occurred. One major complication has been reported in which **radiation necrosis** occurred during postoperative therapy, leading to progressive devitalization of the pericranial flap. Ultimately, dural repair and closure with a latissimus dorsi free flap was required. The pericranial flap repair of anterior skull base defects has a 90% complication-free and 95% overall success rate. It is simple and extremely effective. Bone grafting has not been necessary in there experience ¹⁾.

Malignant lesions of the fronto-ethmoid sinuses and the nasal septum are rare. They typically manifest late in their course and can quickly spread to surrounding vital structures. Consequently, curative treatment usually consists of multimodality therapy, incorporating a combination of surgery and radiation.

One of the documented complications of this modality of treatment is the development of nasocutaneous fistulas in the region of the medial orbital wall and upper lateral nose. These fistulas often drain mucopurulent fluid and can cause orbital infections and skin breakdown. Historically, these fistulas have been repaired using local skin flaps, median forehead flaps, or even primary closure. Newman et al., presented an alternative method for closing these fistulas using a pericranial flap ²⁾.

A 26-year-old woman was admitted with multiple facial bone fractures identified using facial bone computed tomography. Plastic surgeons performed surgery under general anesthesia for the patient's nasal bone fractures. On the seventh day after admission, the patient's brain computed tomography showed an abscess in the frontal lobe. Antibiotic treatment was started, but the lesion deteriorated. Anterior skull base reconstruction was then performed using a pericranial flap with **gelfoam**

compression. No complications, including leakage of cerebrospinal fluid, cerebral hemorrhage, necrosis of the pericranial flap, or frontal lobe herniation, were observed 1 year following surgery.

In this case, Song et al., performed a simple and effective treatment with reconstruction using pericranial flap and gelfoam compression without complications. This technique is useful for reconstructing defects in the base of the [frontal bone](#) resulting from various causes, as well as for fracture of the [anterior skull base](#) following trauma ³⁾.

Unclassified articles

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