PREOPERATIVE DIAGNOSIS: , Status post Mohs resection epithelial skin malignancy left lower lid, left lateral canthus, and left upper lid.,POSTOPERATIVE DIAGNOSIS: , Status post Mohs resection epithelial skin malignancy left lower lid, left lateral canthus, and left upper lid.,PROCEDURES:,1. Repair of one-half full-thickness left lower lid defect by tarsoconjunctival pedicle flap from left upper lid to left lower lid.,2. Repair of left upper and lateral canthal defect by primary approximation to lateral canthal tendon remnant.,ASSISTANT: , None.,ANESTHESIA: , Attended local by Strickland and Associates.,COMPLICATIONS: , None.,DESCRIPTION OF PROCEDURE: , The patient was taken to the operating room, placed in supine position. Dressing was removed from the left eye, which revealed the defect as noted above. After systemic administration of alfentanil, local anesthetic was infiltrated into the left upper lid, left lateral canthus, and left lower eyelid. The patient was prepped and draped in the usual ophthalmic fashion. Protective scleral shell was placed in the left eye. A 4-0 silk traction sutures placed through the upper eyelid margin. The medial aspect of the remaining lower eyelid was freshened with straight iris scissors and fibrin was removed from the inferior aspect of the wound. The eyelid was everted and a tarsoconjunctival pedicle flap was developed by incision of the tarsus approximately 3-1/2-4 mm from the lid margin the full width of the eyelid. Relaxing incisions were made both medially and laterally and Mueller's muscle was subsequently dissected free from the superior tarsal border. The

tarsoconjunctival pedicle was then anchored to the lateral orbital rim with two interrupted 6-0 Vicryl sutures and one 4-0 Vicryl suture. The protective scleral shell was removed from the eye. The medial aspect of the eyelid was advanced temporally. The tarsoconjunctival pedicle was then cut to size and the tarsus was anchored to the medial aspect of the eyelid with multiple interrupted 6-0 Vicryl sutures. The conjunctiva and lower lid retractors were attached to the advanced tarsal edge with a running 7-0 Vicryl suture. The upper eyelid wound was present. It was advanced to the advanced tarsoconjunctival pedicle temporally. The conjunctival pedicle was slightly trimmed to make a lateral canthal tendon and the upper eyelid was advanced to the tarsoconjunctival pedicle temporally with an interrupted 6-0 Vicryl suture, it was then secured to the lateral orbital rim with two interrupted 6-0 Vicryl sutures. Skin muscle flap was then elevated, was draped superiorly and nasally and was anchored to the medial aspect of the eyelid with interrupted 7-0 Vicryl sutures. Burrows triangle was removed as was necessary to create smooth wound closure, which was closed with interrupted 7-0 Vicryl suture. Temporally the orbicularis was resuspended from the advanced skin muscle flap with interrupted 6-0 Vicryl suture to the periosteum overlying the lateral orbital rim. The skin muscle flap was secured to the underlying tarsoconjunctival pedicle with vertical mattress sutures of 7-0 Vicryl followed by wound closure temporally with interrupted 7-0 Vicryl suture with removal of a burrow's triangle as was necessary to create smooth wound closure.

Erythromycin ointment was then applied to the eye and to the wound followed by multiple eye pads with moderate pressure. The patient tolerated the procedure well and left the operating room in excellent condition. There were no apparent complications.