



COMMENTARY

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Perception of Surgical Anatomy and Reconstructive Technique for Defects of the Scalp

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Description

Scalp reconstruction is a surgical procedure for people with scalp defects. Scalp defects may be partial or full thickness and can be congenital or acquired. Because not all layers of the scalp are elastic and the scalp has a convex shape, the use of primary closure is limited. It's not always optimal or best to close a wound in the quickest and simplest way possible. The decision to reconstruct depends on a number of variables, including the nature of the defect, the patient's traits, and the surgeon's preference.

Congenital and acquired conditions are the two main categories for scalp repair. Aplasia cutis congenita, congenital nevus, congenital vascular abnormalities, and congenital cancers are examples of congenital deformities. Burns, traumatic, penetrating, or avulsion injuries, tumour invasion, infection, oncologic excision, radiation, or problems with wound healing can all result in acquired abnormalities. Alopecia may serve as a cosmetic justification for reconstructed scalps with hair. As basal-cell carcinoma and squamous-cell carcinoma rates are rising and about 80% of these cancers are found in the head and neck region, more scalp reconstructions are likely to be performed in the future. The best reconstructive technique must be used based on the size and type of the defect. By using Mohs surgery the defect can be kept minimal, but nevertheless infiltrative basal cell carcinoma may have the need to remove a large part of the scalp.

A condensed algorithm for scalp reconstruction is shown on the flowchart. Options include straightforward fixes for minor skin imperfections and intricate reconstructions requiring many tissue reconstructions.

Before reconstruction is done, an active, serious in-

fection must be treated with antibiotics and surgical debridement because it can lead to bacteraemia and impair wound healing.

Surgical anatomy

By employing the mnemonic SCALP, it is simple to remember the five layers of the scalp, which range from superficial to deep. Scientific testing has been done to measure the thickness of scalp skin. The thickness of the skin on the posterior scalp is 1.48 mm, that of the skin on the temporal scalp is 1.38 mm, and that of the anterior scalp is 1.18 mm. There are roughly 100,000 hairs on the scalp. Scalp regeneration is challenging because hair lines must be respected to produce a pleasing visual result. A layer of fat called the subcutis is divided into compartments by stiff, fibrous septa. Because they are rigid, bleeding vessels cannot constrict and retract beneath the skin to achieve haemostasis. All large blood vessels and nerves of the scalp are located in this layer. The galea Aponeurotica, which divides the overlaying layers from the underlying bone, is the next layer. This layer is not penetrated by the main blood arteries or the scalp's nerves. The periosteum and aponeurosis are two stiff structures that can readily slide over one another due to loose connective tissue, which aids in skin mobility. Thus, the skin, subcutaneous tissue, and galea aponeurotica can be removed off the skull with little bleeding, nerve damage, or risk of necrosis if vascular and neurological anatomy are respected. Orticochea first described this technique in 1967; however it has since been improved to reduce scarring. The Periosteum of the skull, also known as pericranium, is the fifth layer. It can be separated from the skull, except near the sutures. The skull consists of an inner and outer table, with spongy bone in between known as diploë.

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