Surgical Management of Auricular Infantile Hemangiomas

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Objective: To report our experience with surgical management of auricular infantile hemangiomas and reconstruction of the affected ear.

Design: Retrospective case series.

Setting: Dedicated Birthmarks and Vascular Anomalies Center in a tertiary pediatric hospital.

Patients: Ten patients with surgically treated, histopathologically confirmed auricular infantile hemangiomas.

Main Outcome Measures: Outcomes of surgical management.

Results: The case series included 5 male and 5 female patients (age range, 4 months to 4 years). Indications for surgery were pain, bleeding, infection, and cosmetic deformity. Four patients had failed prior medical treatment, including pulsed dye laser, topical corticosteroids, and intralesional corticosteroids. Nine patients underwent single-stage resection. Otoplasty reconstruction was performed in 2 patients with hemangioma-induced deformities, while primary Z-plasty closure was performed in 2 patients with extensive lesions. No recurrence or complication has been reported to date.

Conclusions: Most infantile hemangiomas do not require treatment. Surgical excision of auricular infantile hemangiomas at any phase is effective in preventing fibrofatty scarring, reducing cartilage deformities, and treating complicated cases or patients who have failed medical management. Surgical excision with Z-plasty reconstruction is a viable option that should be considered to limit postoperative deformities.


INFANTILE HEMANGIOMAS (IHs) are congenital vascular tumors that affect approximately 10% of the population. They are more common in female and premature infants and among those of white race/ethnicity. In contrast to vascular malformations, which primarily consist of enlarging aberrant vessels or lymph channels, IHs are composed of rapidly dividing endothelial cells. Infantile hemangiomas are not typically present at birth but are observed within the first year of life. Infantile hemangiomas manifest proliferative, involuting, and involuted phases. The proliferative phase typically lasts 6 to 12 months and is uncomplicated for most patients. However, involution can be a slow process that may last through the first decade of life. Treatment is usually deferred unless there is ulceration, bleeding, functional impairment, cosmetic deformity, or shunting. Medical management includes the use of corticosteroids, pulsed dye laser, and β-blocker therapy. These options have variable outcomes and unpredictable adverse effects. Propranolol hydrochloride therapy has been promising in reducing medical treatment of IHs, but tumors in high-risk locations or patients in whom β-blocker therapy is contraindicated may require surgical intervention.

Surgical excision is a secondary treatment option in complicated cases or for large IHs that are expected to result in permanent deformities if allowed to follow their natural course. Approximately 80% of IHs involving skin and soft tissue are located in the head and neck region. Auricular IHs deserve special attention because cartilage deformity caused by large tumors is permanent. The anatomy, location, functional and cosmetic importance of the ear in development are considerations that may necessitate medical or surgical therapy of IHs before involution. Herein, we describe a series of patients with auricular IHs at different phases that were successfully treated with surgical excision and primary reconstruction.

METHODS

This retrospective case series was approved by the Children’s Hospital of Wisconsin institutional review board. We reviewed patients with auricular IHs who had been prospectively fol-
Ten cases (5 male and 5 female) were identified. Seven were of white race/ethnicity, and 3 were Hispanic. The Table summarizes demographic details, clinical presentation, preoperative medical therapy, surgical treatment, and long-term follow-up results were reviewed. Cases without glucose transporter 1 immunoreactivity were excluded. Lesions involving the external auditory canal, tympanic membrane, or middle ear were excluded as well.

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## RESULTS

### Table. Summary of Surgically Excised Auricular Infantile Hemangiomas

<table>
<thead>
<tr>
<th>Case No./Sex/Age</th>
<th>Involved Anatomy</th>
<th>Prior Treatment</th>
<th>Indication for Surgery</th>
<th>Surgical Procedure After Excision</th>
<th>Histopathological Phase</th>
<th>Size, cm²</th>
<th>Blood Loss, mL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/M/4 mo</td>
<td>Lobule, helix, postauricular skin</td>
<td>None</td>
<td>Recurrent bleeding, pain</td>
<td>CC</td>
<td>Proliferative</td>
<td>9.9</td>
<td>&lt;5</td>
</tr>
<tr>
<td>2/M/7 mo</td>
<td>Postauricular skin</td>
<td>None</td>
<td>Pain, ulceration</td>
<td>Z-plasty</td>
<td>Proliferative</td>
<td>1.6</td>
<td>&lt;5</td>
</tr>
<tr>
<td>3/M/9 mo</td>
<td>Lobule, helical rim, postauricular skin in stage 1 and helix in stage 2</td>
<td>Intralosial triamcinolone acetonide injection</td>
<td>Recurrent bleeding, pain, deformity, infection</td>
<td>Z-plasty</td>
<td>Proliferative</td>
<td>29.1</td>
<td>80</td>
</tr>
<tr>
<td>4/M/10 mo</td>
<td>Postauricular skin, helix</td>
<td>None</td>
<td>Deformity</td>
<td>CC</td>
<td>Involuting</td>
<td>0.8</td>
<td>&lt;5</td>
</tr>
<tr>
<td>5/F/15 mo</td>
<td>Postauricular skin, helix</td>
<td>None</td>
<td>Deformity</td>
<td>SC</td>
<td>Involuting</td>
<td>2.2</td>
<td>&lt;5</td>
</tr>
<tr>
<td>6/F/15 mo</td>
<td>Postauricular skin, helix</td>
<td>Intralesional triamcinolone acetonide injection</td>
<td>Recurrent bleeding, hypertrophic scar</td>
<td>CC</td>
<td>Involuting</td>
<td>6.3</td>
<td>&lt;5</td>
</tr>
<tr>
<td>7/F/19 mo</td>
<td>Postauricular skin</td>
<td>None</td>
<td>Recurrent bleeding, deformity</td>
<td>CC</td>
<td>Involuting</td>
<td>6.0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>8/M/19 mo</td>
<td>Postauricular skin, helix</td>
<td>Pulsed dye laser</td>
<td>Cup-ear deformity</td>
<td>Otoplasty</td>
<td>Involuting</td>
<td>3.5</td>
<td>25</td>
</tr>
<tr>
<td>9/F/20 mo</td>
<td>Concha bowl, helix</td>
<td>Topical triamcinolone</td>
<td>Deformity</td>
<td>SC</td>
<td>Involuted</td>
<td>0.6</td>
<td>&lt;5</td>
</tr>
<tr>
<td>10/F/4 y</td>
<td>Preauricular skin, tragus, lobule</td>
<td>Pulsed dye laser</td>
<td>Cup-ear deformity</td>
<td>Otoplasty</td>
<td>Involuted</td>
<td>8.5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

Abbreviations: CC, complex closure; SC, simple closure.

Indications for surgery included cosmetic deformity, bleeding, pain, and infection (Figure 1 and Figure 2).

Five patients underwent surgery with complex closure, 2 patients required otoplasty to address cup-ear deformity, and 2 patients had Z-plasty closure. Representative Z-plasty closure is shown in Figure 2. The median and mean surface areas of lesions were 3.2 and 5.3 cm², respectively. The median volume of lesions from histopathological reports was 4.75 cm³. There were no complications. Follow-up periods ranged from 12 to 48 months, and no recurrence or hypertrophic wound healing has been reported to date.

### COMMENT

The indications for surgery in this series were pain, recurrent bleeding, and gross cosmetic deformity with or without cartilage destruction. These occurred during proliferative and involuting phases. Surgical therapy for IHs has traditionally been reserved for...
postinvolution deformities. However, some advocate early intervention to limit potential morbidity from complications during the proliferative phase and to address postinvolution deformity.6 Historically, available medical treatment tends to arrest growth rather than accelerate lesions toward involution. Beta-blocker therapy has been effective, with few adverse effects, but surgical management has an important role among patients in whom medical treatment is complicated or who have IHs in high-risk locations. Surgical treatment accomplishes resolution of the tumor and addresses any existing cosmetic deformity.

Head and neck lesions are often candidates for intervention because they are conspicuous, represent high-risk locations for complications, and have a propensity to involve functional issues. Auricular IHs require a careful approach because they are vulnerable to bleeding from minor trauma owing to prominence and easy access. In addition, large auricular IHs can cause functional impairment and permanent deformity of the cartilaginous framework. Minor defects involving the helical rim, postauricular sulcus, and antihelix significantly alter shape, position, and contour of the ear.7 Furthermore, the social effect of a normal-appearing ear should not be underestimated. Deformities of the pinna may occur after involution of auricular IHs, and parents may react with grief, psychological distress, and fear of social stigmatization.8,9 Therefore, with the appropriate indication, excision and reconstruction beyond simple closure should be considered.

Our experience suggests that it is safe and prudent to intervene during the proliferative phases for patients in whom nonsurgical therapy is not achieving acceptable outcomes. However, the timing of surgery may be challenging for uncomplicated lesions that are expected to cause permanent deformity. In this series, 3 patients younger than 9 months had complicated proliferative lesions that required multiple visits to the hospital. Previous research has demonstrated that most IHs complete growth by 5 months and almost all cease to grow by 9 months.10 Therefore, parents or guardians of a patient with auricular IHs should be counseled about the potential need for early referral to a surgeon as part of the patient’s multidisciplinary team. The site involved may also influence referral for surgical consultation. Most tumors in this case series involved the helix, antihelix, lobule, and postauricular sulcus. These sites may increase the propensity for deformity, in contrast to loss of cartilage in the concha bowl, scaphoid fossa, and triangular fossa, where involuting IHs are less likely to permanently alter the anthropometrics of the pinna.7

Small superficial defects of the auricle and surrounding skin are amenable to primary closure with adequate undermining and tissue rearrangement. However, the deep nature of auricular IHs herein precluded primary closure of all lesions in this series. The lesions were entirely removed through dissection down to subcutaneous tissue and postauricular fascia (when applicable) without extensive cartilage removal. This curative approach left surgical defects that required reconstructive options. Although lesions on concave surfaces of the ear may heal well via secondary intention, the unacceptable cosmesis and potential for disfigurement due to wound contraction made secondary intention an unacceptable option in this population. Complex closure involves undermining, placement of deep sutures in subcutaneous tissue, and local flap reconstruction with or without excision of Burrow triangles. There are multiple options for tissue rearrangement in subsite sites of the pinna.7,10,11 Of note, 2 patients herein required otoplasty owing to cup-ear deformity caused by postinvolution fibrofatty tissue. For otoplasty cases, the postauricular deformities were excised in a fusiform manner. This was followed by placement of conchomastoid sutures to reduce the auriculomastoid angle and then horizontal mattress sutures (Mustardé sutures) along the scapha to recreate the antihelical fold.12 No lobule reduction or repositioning was performed. A similar approach was used in patients with single Z-plasty closure, where the surgical wound served as the central limb of the triangular flaps. These techniques should be considered when primary closure does not provide optimal results.

In conclusion, IHs spontaneously regress with time, and most patients do not require treatment. Surgical excision is effective in avoiding deformities, removing complicated IHs, and treating patients who have failed medi-
cal management. Z-plasty reconstruction yields an excellent cosmetic outcome.

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REFERENCES


