

*Case Report***Ear Lobe Cleft Correction by “Simplest Technique”- A Case Report**

Singh SK, Thapliyal GK, Singh N, Shukla A

**Abstract:** Split earlobe usually results from sudden trauma or continuous use of heavy earrings. Among the various surgical techniques proposed for split earlobe correction, the choice will depend on the existing split, partial or total, and should offer a lower chance of recurrence. The total split corrections may be made with or without preservation of the earring orifice. Lobe fixation during intervention is essential, whatever the technique used, and can be done with tongue blade or sterile chalazion clamp. For the surgical procedure, we used Adson clamp, iris scissors, and scalpel blade 11 or 15. Skin suture was done with mono-nylon 5.0 or 6.0. The objective of this study is to present the technique, results, and outcomes of our split earlobe patient. We perform a complete closure without preservation of the original piercing hole.

Keywords: Earlobe cleft; Clamp; Chalazion; Keloid; Bacitracin; Plasty.

**INTRODUCTION**

The ear lobe occupies a unique position among facial structures and is particularly important due to the secular tradition of people wearing decoration and jewellery in this place. This issue of perforating the ear lobe comes from time immemorial and, depending on the culture it happens even as a social obligation. Latin-American cultures have routinely pierced the ears of newborn baby girls, to differentiate them from males. In the tribes of Ivan and Kayan, in Africa, ear lobes were decorated with large and heavy earrings, thus causing an enlargement and elongation of the lobe hole.<sup>1</sup>

Moreover, there is a current trend of using increasingly more decorations in this region, causing a greater local tension and structural alterations arising from these new habits, even in males. All of this has motivated a greater number of patients to seek specialized treatment for cosmetic alterations in their earlobes.<sup>2</sup> There are a number of causes and/or alterations that require surgical treatment. Among them, we can mention:<sup>3,4</sup>

- Ear lobe clefts or lacerations secondary to trauma;
- Congenital alterations;
- Facial aging;
- Keloids;
- Ear lobe tumors.

**Many techniques have been described for the correction of ear lobe clefts.**<sup>1,5,6,7</sup>

- Direct suturing;

- Zetaplasty;
- Ritidoplasty with ear lobe correction;
- V-shaped flaps;
- L-shaped flaps;

This article describes a technique that is Simple scar excision with reapproximation of skin edges.

**CASE REPORT**

A 25 year old female patient reported to the Department of Oral and maxillofacial surgery Rama Dental College and Hospital, Kanpur with complains of incomplete cleft earlobe due to prolong traction of heavy earrings (Fig 1).



*Figure 1: Preoperative photograph showing incomplete clefting of right ear.*

**TECHNIQUE**

In the evaluation of the cleft earlobe repair, it is important to first determine the length of the cleft. Incomplete clefts can be repaired without sacrificing the inferior lobe margin. However, total excision through the inferior portion of the lobe is recommended if the defect extends to the lower third of the earlobe. This decreases or prevents bunching of the repair, insuring a more cosmetic

closure. We used the surgical approach described below.

The procedure was performed under local anaesthesia. After anaesthetic infiltration, the inferior lobe margins were stretched with a fine skin hook to show the actual anatomic extent of the cleft and the interposed scar tissue, holding a sterile tongue blade behind the earlobe to provide a solid cutting surface while the scar tissue is excised. The epithelial margins were excised and re-approximated with 6-O nylon suture (Fig 2). A pressure dressing with Bacitracin ointment was then applied to the wound, which was removed in 24 hours. The patient was advised to apply Bacitracin ointment and keep a Band-Aid on the wound until suture removal, which is usually seven to ten days, post-operative.



*Figure 2: Intra operative photograph showing closure done with 6-0 prolene on right ear.*

## RESULT

We have had excellent result with surgical repair of the dilated earlobe after ear gauging. Postoperative photographs shows minimal scar and no inferior lobe notching (Fig 3).

## DISCUSSION

In India, ear lobes are universally pierced as a ritual before the age of 1 year among females of all races and also in specific castes of males too, in adolescence. The ear lobes, consequently, are made to bear the brunt of metal ornaments very early in life. The initial ear ornament is commonly either a stud or a small ring, but later on, in adolescence and later years, there is a gradual shift to 'danglers' and frequent use of heavy earrings. These type of earrings, especially in young mothers, are prone to being yanked by children or may suffer

similar kinds of acute severe pull or entanglement due to other reasons.<sup>8</sup>



*Figure 3: Post operative photograph showing complete closure of clefting after 15 days and with no obvious scar on right ear.*

Many are the techniques that have been described for the surgical treatment of ear lobes. In 1954, McLaren suggested a mild scraping of the cleft borders and simple margin suturing.<sup>2,5</sup> Besides not keeping the lobe orifice, simple suturing favours the formation of a notch. In 1961, Boo-chai, proposed the excision of part of the cleft borders and suturing below the original orifice.

In 1973, Pardue proposed the resection of the cleft borders, leaving a piece of skin on the upper part of one of the sides, which will be used to build the lobe orifice.<sup>3,5</sup> Although attempting to keep the orifice, these two techniques favor the notch formation or a level difference in the lower lobe margin. In 1975, Hamilton and La Rossa described a similar technique to Pardue's, associated to a zetaplasty in an attempt to minimize the notch formation. Although this new approach tried to keep the orifice open and avoid the notch, it is technically more challenging than the approach described in the present paper. In 1978, Argamasso, described a similar approach which left intact skin near the original orifice, and in each half of the lobe it created two triangular flaps, to be sutured afterwards.<sup>3,5</sup>

In 1982, Harak, proposed tissue excision on the anterior face of one of the borders and then, the same amount of tissue is to be removed on the posterior face of the other border. This approach also did not preserve the lobe orifice.<sup>5</sup> Kalimuthu et al. proposed the "V"-shaped flap approach. Fatah (1985) and Fearon & Cuadros (1990), proposed the

“L”-shaped flap, which also does not keep the lobe orifice open.<sup>2</sup> Although numerous “plasty” methods have been described to repair complete and incomplete acquired clefts, it is our experience that complicated tissues are difficult to handle such as on the fleshy and mobile tissues of the earlobe. Simple scar excision with reapproximation of skin edges has been described in the literature and is adequate for excellent postoperative results. Immediate placement of earrings at the time of repair may be requested by patients and is a viable alternative.<sup>2</sup>

**CONCLUSION:** When choosing the best option for split earlobe repair, we must consider all factors that will influence the final outcome, such as lobe size, cleft type (partial or total), number of orifices already existing, and a tendency to non-aesthetic scars. Considering the technical possibilities, we chose the simple technique that will leave the lobe more like the original. It achieves a solid repair of the earlobe cleft without risk of future notching. Preserving the earring hole is not an aim of this method. Patients can either use clip-on earrings or have new holes made after healing. It is important to choose the technique most appropriate to each case, allowing the smallest chance of recurrence.

**Author affiliations:** 1. Dr. Shivendra Kumar Singh, PG student, 2. Dr. (Maj. Gen.) G.K. Thapliyal, SM (Retd.), MDS, Professor & HOD, 3. Dr. Nishant Singh, MDS, Reader, 4. Dr. Ashutosh Skula, MDS, Senior lecturer, Dept. of Oral and Maxillofacial Surgery, Rama Dental College Hospital and Research Centre, Kanpur, U.P. India.

## REFERENCES

1. Abrahams PH. Earlobe Z-plasty in Borneo. *Plast Reconstr Surg* 1974;53:548-550.
2. Fearon J and Cuadros CL. Cleft earlobe repair. *Ann Plast Surg* 1990;24(3):252-257.
3. Venkatramani H. A new technique in closure of wide clefts of earlobule. *Plast Reconstr Surg* 1999;104(1):296-297.
4. Clevens RA, Baker RS. Plastic and reconstructive surgery of the earlobe. *Facial Plast Surg* 1995;11(4):301-309.
5. Rich JD, Gottlieb V, Shesol BF. A simple method for correction of the pixie earlobe. *Plast Reconstr Surg* 1982;69(1):136-138.
6. Effendi SH. Reconstruction of the middle-aged torn earlobe: a new method. *Br J Plast Surg* 1988;41(2):174-176.
7. Blanco-Davila F, Vasconez HC. The cleft earlobe: a review of methods of treatment. *Ann Plast Surg* 1994;33(6):677-680.
8. Niamtu J. Eleven pearls for cosmetic earlobe repair. *Dermatol Surg*, 2002;28:180-185.

## Corresponding Author:

Dr. Shivendra Kumar Singh,  
PG student,  
Dept. of Oral and Maxillofacial Surgery,  
Rama Dental College Hospital and Research  
Centre, Kanpur, U.P. India  
E mail: rishivaranasi@gmail.com

**How to cite this article:** Singh SK, Thapliyal GK, Singh N, Shukla A. Ear Lobe Cleft Correction by “Simplest Technique”- A Case Report. *Rama Univ J Dent Sci* 2015 Sept.;2(3):54-56.

**Sources of support:** Nil

**Conflict of Interest:** None declared