

infiltration of 2-5 ml Lidocain 1% with adrenalin. Donor site and place from the mucous membrane for taking graft were also infiltrated with 2-5 ml Lidocain. After the operation, all patient were completely active. Outpatients were controlled for 48 hours, 4 days and beetwen 7-10 days for taking strings away. All patients were given tabl.Bactrim 480 mg 2x2 for 5 days.

**TABLE 2** Topographic distribution of BCC

Tumor localization	Number of cases
Inferior eyelid	20
Medial canthus	9
Superior eyelid	4
Lateral canthus	3
Total:	36

### Pre-operative evaluation

Prior to the operation, all patients were examined completely for eye functioning and periorbital area. Attention has to be paid to the tonus of the eyelid and periorbital skin. Periocular tissue is more elastic if the patient is older. Flexibility of the skin is important for planning the reconstruction of the eyelids. If in the past, the patients had been operated, had radiation or burns, their eyelids are thick, hard with problematic healing, that cause problems in reconstruction. The operation may be performed in one or two acts, in order to achieve good function of the lacrimal glands.

### Surgical treatment

Evaluation for the radicalizm of the operation is done visually and with tactile impresion by fingers according to the principle of Whitening (1951), then the principle of radicalizm of minimum 4 mm in healthy tissue from the cancer's border line is also used.

The followinf techniques were used: muscular-skin flaps (15), full-thickness skin grafts and split skin grafts (8), direct closure (12) and spontaneous closure.

### Direct closure

Lid skin defects, such as those created after excision of superficial skin lesions should be closed vertically. This pulls in skin horizontally and thus avoids verti-

cal shortening, which could lead to cicatricial ectropion. Although such closure is perpendicular to the normal lid creases, and as such is contrary to the general rules for incision siting, such incisions generally heal well and do not cause cosmetic problems.

### Cantholysis

The lateral or medial canthal tendons are cut in order to allow a lid fragment to slide laterally or medially on its conjunctival and skin pedicle. This procedure is useful for the direct closure of a lid defect when more than a third of the lid has been removed and direct closure would not otherwise be possible. It may also be used as part of a cheek rotation flap in order to advance the remaining fragment of tarsus and conjunctiva to a precorneal position.

### Free skin grafts

Split skin grafts are seldom required on the lids and owing to their inherent shrinkage are not a good form of cover in this region. However, they are useful for covering extensive adjacent skin defects on the brow, temple or cheek.

Full-thickness skin grafts are used for reconstruction of the inferior eyelid together with free mucosis flap (Mehta, 1977) or with tarsoconjunctival flap (Holstrom, 1975). Full-thickness skin transplantation is technique that can be used for many cancer of eyelids and periorbital area. Full-thickness flap is fixed by Mehta technique. This is made with central and paracentral suture, that allows activities after the operation, and makes this operation to be maked as a day case. The best donor source is the opposite upper lid skin. Alternative donor sites include postauricular skin, supraclavicular fossa skin and the skin on the inner aspect of the upper arm.

### Glabellar flap

This is a useful flap for the repair of medial canthal skin defects in those who have marked forehead frown lines. The flap is essentially a semicircular rotation flap that has been modified in order to place the scars in the direction of natural lines. The flap must be anchored to the medial canthal tendon or periosteum in the medial hollow to conform with the contour of the region. This should be closed in two layers with adequate absorbable subcutaneous sutures to allow for the early removal of the brow skin sutures.