

Nasal Alar Reconstruction with a Bilobed Flap Following Resection of Micronodular Basal Cell Carcinoma: An Oncologic and Reconstructive Approach

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ABSTRACT

Introduction. Basal cell carcinoma is the most common malignant cutaneous neoplasm and accounts for most non-melanoma skin cancers. Despite its low metastatic potential, it may exhibit locally aggressive behavior, particularly in high-risk anatomical regions such as the nose and in aggressive histological subtypes, including the micronodular variant. Involvement of the nasal ala represents a significant therapeutic challenge, as management must integrate the principles of complete oncologic resection with optimal functional and aesthetic reconstruction. In this context, local flaps represent a valuable reconstructive option, and the bilobed flap remains a reliable technique for small to medium-sized nasal defects due to its versatility, favorable tissue match, and ability to achieve reconstruction in a single surgical stage.

Objective. To describe the diagnostic approach, surgical management, and immediate reconstruction of a micronodular basal cell carcinoma located on the left nasal ala, as well as to highlight the utility of the bilobed flap as a reconstructive option for nasal defects following oncologic resection.

Materials and Methods. A 54-year-old female patient is presented, with a history of systemic arterial hypertension, chronic occasional tobacco use, and prior superficial parotidectomy for benign disease, who presented with a dermal lesion on the left nasal ala of one year's duration with progressive growth. On physical examination, a nodular lesion measuring approximately 1 cm was identified, with poorly defined borders, pigmentation, and central ulceration, without evidence of deep tissue invasion. An incisional biopsy was performed on October 10, 2025, yielding a histopathological diagnosis of ulcerated, pigmented micronodular basal cell carcinoma. Given the high-risk histological subtype and the anatomical location, surgical treatment was indicated. A wide three-dimensional excision with 1 cm safety margins was performed, followed by immediate reconstruction using a bilobed flap designed according to nasal subunit principles. The procedure was completed without complications, and the flap demonstrated adequate viability in the immediate postoperative period.

ARTICLE DETAILS

Published On:
22 April 2026

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Results. During the surgical procedure, an exophytic nodular lesion measuring approximately 1 cm in diameter was identified on the left nasal ala. A wide three-dimensional excision was performed, with adequate circumferential and deep margins to ensure optimal oncologic control. The resulting defect was immediately reconstructed using a bilobed flap, allowing coverage with local tissue of similar characteristics, appropriate redistribution of tension, and preservation of the nasal contour. In the immediate postoperative period, the patient remained hemodynamically stable, with a Glasgow Coma Scale score of 15, fully oriented, without evidence of active bleeding, and with adequate flap viability, with no immediate complications.

Conclusions. Micronodular basal cell carcinoma located on the nasal ala represents a high-risk entity due to both its anatomical location and its infiltrative histological pattern, requiring a surgical approach with strict adherence to oncologic principles. Wide three-dimensional excision followed by immediate reconstruction using a bilobed flap constitutes a safe and effective option in selected cases, as it allows adequate tumor control while achieving functional and aesthetic restoration in a single surgical stage. In this context, the bilobed flap remains a valuable reconstructive tool in facial plastic surgery, particularly for small to medium-sized defects of the distal nasal third.

KEYWORDS: Basal cell carcinoma, micronodular, nasal ala, bilobed flap, nasal reconstruction, oncologic surgery, reconstructive plastic surgery

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INTRODUCTION

Basal cell carcinoma (BCC) is the most common malignant neoplasm of the skin and the predominant subtype within the group of non-melanoma skin cancers. Its clinical relevance is explained not only by its high incidence but also by the progressive increase in its frequency over recent decades, which has been associated with population aging, cumulative and intermittent exposure to ultraviolet radiation, changes in sun-exposure behaviors, improved survival of immunosuppressed patients, and earlier diagnostic detection. Although BCC has a very low metastatic potential, its capacity for local invasion can be considerable, particularly when located in anatomically complex regions or when associated with aggressive histological subtypes. Consequently, basal cell carcinoma should not be regarded as a “benign” neoplasm due to its low mortality, but rather as an oncologic entity capable of causing significant tissue destruction, functional impairment, and aesthetic deformity, especially in the centrofacial region.

The head and neck represent the most common anatomical location for basal cell carcinoma, and within this region, the nose holds particular clinical significance. Cumulative sun exposure, the complex three-dimensional configuration of its subunits, and the limited tissue laxity make the nasal dorsum, tip, and ala especially challenging areas for treatment. In these regions, management cannot be limited solely to oncologic eradication but must also address, simultaneously, the preservation of facial symmetry, respiratory function, and the integrity of nasal aesthetic subunits. Tumor resection of the nasal ala is particularly delicate, as even small defects may result in alar retraction, collapse of the external nasal valve, asymmetry, and distortion of the nasal contour. This

underscores the need for meticulous surgical planning and an individualized reconstructive strategy.

From a histopathological perspective, basal cell carcinoma encompasses a heterogeneous spectrum of variants, including nodular, superficial, infiltrative, basosquamous, and micronodular subtypes. This classification is not merely descriptive but carries direct prognostic implications. The micronodular subtype is recognized as a more aggressive variant compared to conventional nodular BCC, due to its tendency to form small tumor nests that infiltrate the dermis with greater subclinical extension and less well-defined clinical margins. This characteristic results in a higher likelihood of incomplete excision when insufficient surgical margins are used, as well as an increased risk of local recurrence. In high-risk anatomical areas such as the nasal ala, the presence of this histological subtype necessitates a more cautious and oncologically aggressive therapeutic approach.

The diagnostic approach to basal cell carcinoma integrates clinical evaluation, dermoscopy, and histopathological confirmation. The lesion typically presents as a pearly papule or nodule, sometimes pigmented, with superficial telangiectasias, ulceration, or occasional bleeding. However, clinical presentation may vary widely, and in infiltrative or micronodular subtypes, the true extent of the tumor may exceed what is apparent on inspection. For this reason, biopsy remains essential to establish a definitive diagnosis, characterize the histological subtype, and guide therapeutic decision-making. In selected cases—particularly when there is suspicion of deep invasion or involvement of adjacent structures—complementary imaging studies may be employed; however, in most cases, the cornerstone of diagnosis remains the clinicopathological correlation.

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From a therapeutic standpoint, surgery remains the treatment of choice for most basal cell carcinomas, as it allows complete tumor excision and histological assessment of margins. The selection between conventional excision, Mohs micrographic surgery, or alternative modalities depends on tumor size, anatomical location, clinical margins, histological subtype, and history of recurrence. In high-risk lesions located on the nose, surgical decision-making must be guided by a balance between oncologic radicality and tissue preservation. However, when the tumor exhibits an aggressive histological pattern, such as the micronodular subtype, the guiding principle should be complete excision, even if this results in a larger reconstructive defect. In this context, the role of plastic and reconstructive surgery is essential, as it allows transformation of an oncologic defect into a planned reconstruction that is both functionally effective and aesthetically acceptable.

Among the various reconstructive options available for nasal defects, local flaps occupy a central role, as they provide tissue with similar characteristics in terms of color, thickness, texture, and skin quality. Among these, the bilobed flap has maintained its relevance since its initial description by Esser and subsequent technical refinement by Zitelli. It is a double transposition local flap with a random vascular pattern, which allows redistribution of tension toward adjacent areas with greater tissue laxity and enables coverage of small to moderate defects, particularly in the distal third of the nose. Its utility lies in its ability to achieve reconstruction in a single surgical stage, with good aesthetic match and minimal need for distant tissue. However, its design requires precise knowledge of tension vectors, nasal subunit anatomy, and potential complications, including alar retraction, trapdoor deformity, venous congestion, and contour asymmetry.

Reconstruction of the nasal ala represents one of the scenarios in which reconstructive judgment must be particularly rigorous. Unlike other facial regions, even minor distortions in this area may lead to disproportionately significant functional and cosmetic consequences. Therefore, flap selection must consider not only the size of the defect but also its depth, involvement of the free alar margin, cartilage compromise, and the need for structural support. In small to moderate cutaneous defects without significant loss of the cartilaginous framework, the bilobed flap represents a useful option when properly designed and oriented according to the most favorable tension lines. However, its use within the context of cutaneous oncologic surgery requires that tumor resection be clearly planned and that reconstruction does not compromise postoperative surveillance or hinder the management of potential recurrences.

The case presented in this study exemplifies the intersection between cutaneous oncology, reconstructive surgery, and functional aesthetic facial surgery. It involves a 54-year-old female patient with an ulcerated, pigmented micronodular basal cell carcinoma located on the left nasal

ala, who underwent wide three-dimensional excision with adequate safety margins followed by immediate reconstruction using a bilobed flap. The relevance of this case lies in the coexistence of several key factors: a high-risk anatomical location, an aggressive histological subtype, and the need to address the resulting defect using a local reconstructive technique in a single surgical stage. This scenario provides an opportunity to review not only the biological foundations of basal cell carcinoma but also the reconstructive principles that guide the management of nasal defects following oncologic resection.

In this context, the aim of the present study is to describe the surgical management of a micronodular basal cell carcinoma of the left nasal ala and, based on this case, to discuss the most relevant aspects of this neoplasm, including its definition, epidemiology, diagnostic approach, histological variants, and both surgical and non-surgical treatment options, with particular emphasis on the role of the bilobed flap as a reconstructive alternative in facial plastic and reconstructive surgery. Additionally, this work seeks to highlight the importance of comprehensive treatment planning that prioritizes oncologic safety while maintaining optimal functional and aesthetic outcomes, which are fundamental principles in the contemporary management of facial cutaneous malignancies.

CASE PRESENTATION

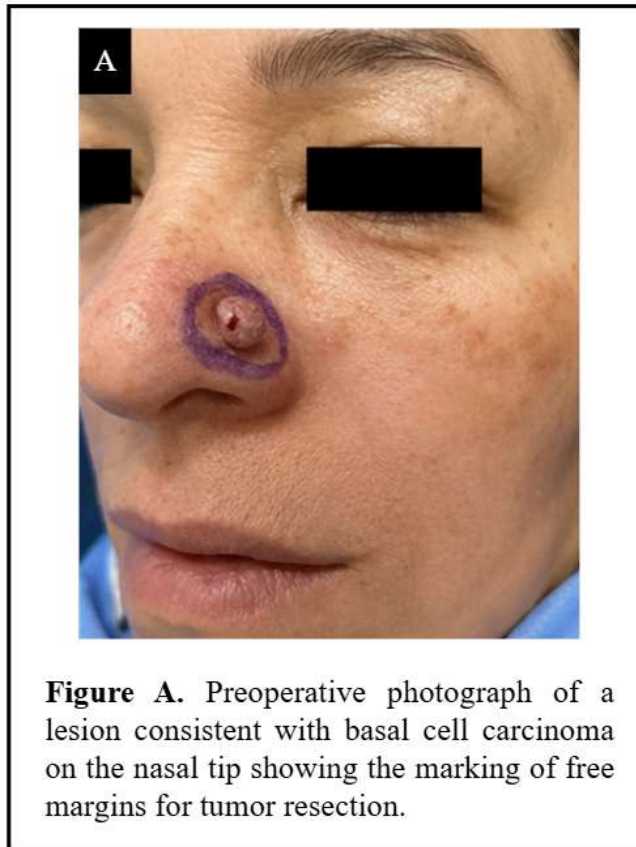
A 54-year-old woman presented for evaluation of a cutaneous lesion in the nasal region. Her past medical history was negative for diabetes mellitus; however, she reported a diagnosis of systemic arterial hypertension approximately one year prior, currently under medical management and control. As a relevant surgical history, she had undergone a superficial parotidectomy in May 2025 for benign disease.

Regarding her social history, the patient reported occasional tobacco use for more than 30 years, with an estimated consumption of up to two cigarettes per month, and no other relevant toxic exposures. She described a dermal lesion located on the left nasal ala with approximately one year of evolution, characterized by progressive increase in size over the months preceding evaluation.

On physical examination, a nodular lesion measuring approximately 1 cm in diameter was identified on the left nasal ala, clinically suggestive of a cutaneous neoplasm, with an irregular surface and mild pigmentation. (*Figure A.*)

As part of the diagnostic workup, an incisional skin biopsy of the left nasal ala was performed on October 10, 2025. Histopathological analysis reported a pigmented micronodular basal cell carcinoma with areas of ulceration. Based on clinical and histopathological findings, a diagnosis of basal cell carcinoma of the left nasal ala was established.

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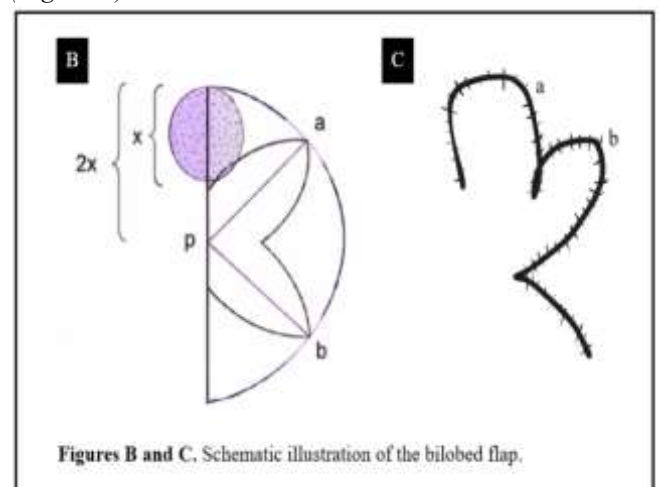


I. Surgical Technique: Following diagnostic confirmation and multidisciplinary evaluation, the patient was scheduled for definitive surgical management. On March 3, 2026, the procedure was performed under sterile conditions, consisting of a wide three-dimensional excision of the tumor in accordance with the principles of cutaneous oncologic surgery. Resection was carried out with circumferential clinical safety margins of approximately 1 cm, including clinically normal surrounding skin. Deep excision of the underlying tissues was also performed, encompassing skin and subcutaneous tissue until macroscopically disease-free anatomical planes were reached, with the aim of ensuring complete tumor removal and minimizing the risk of local recurrence.

Following tumor excision, a cutaneous defect of the left nasal ala was identified, requiring immediate reconstruction. A bilobed flap was therefore designed and executed using adjacent skin with adequate laxity. The flap was planned according to the principles described by Zitelli. The first lobe was designed to match the size of the primary defect, while the second lobe measured approximately 50–60% of the first. Both lobes were designed with a rotation angle of approximately 45–50°, oriented toward the lateral nasal region to take advantage of areas with greater tissue laxity. (Figures B and C.) Dissection was performed in the subcutaneous plane, preserving the vascularity of the pedicle. The first lobe was transposed to cover the primary defect, while the second lobe facilitated closure of the secondary defect. Adequate undermining was performed to minimize

tension, with careful preservation of the alar contour and avoidance of distortion of the external nasal valve. Meticulous hemostasis was maintained throughout the procedure, followed by anatomical-layer fixation of the flap and layered skin closure. The flap demonstrated adequate perfusion and immediate viability, with no evidence of excessive tension or vascular compromise.

In the immediate postoperative period, the patient remained hemodynamically stable, with a Glasgow Coma Scale score of 15, fully oriented to time, place, and person. The surgical wound in the nasal and nasogenian region showed adequate flap perfusion, without evidence of active bleeding or immediate complications. The patient continued with postoperative management and close outpatient follow-up. (Figure D)





DISCUSSION

Basal cell carcinoma (BCC) is a malignant neoplasm derived from the basal cells of the epidermis and adnexal structures, characterized by slow but infiltrative local growth, extremely low metastatic potential, and a marked tendency for tissue destruction when not treated in a timely manner. From an oncologic standpoint, its significance lies not so much in mortality but in its high incidence, its predilection for the centrafacial region, and the functional and aesthetic impact it may produce in critical areas such as the nose, eyelids, medial canthus, auricle, and lips.

From an epidemiological perspective, BCC is the most common form of skin cancer and accounts for the majority of non-melanoma cutaneous tumors. Its incidence continues to rise worldwide, particularly among older adults and in sun-exposed anatomical regions. The main risk factors include cumulative and intermittent ultraviolet radiation exposure, fair skin phototypes, advanced age, male sex in several series, immunosuppression, prior ionizing radiation, genetic susceptibility, and a personal history of skin cancer. The head and neck region, and particularly the nose, represent high-risk locations due to the combination of chronic sun exposure, anatomical complexity, and aesthetic significance.

The diagnosis of basal cell carcinoma (BCC) is initially clinical, supported by dermoscopy, and must be confirmed histopathologically through incisional, excisional, shave, or punch biopsy, depending on the size, location, and level of diagnostic suspicion. Dermoscopy improves diagnostic accuracy and reduces unnecessary biopsies, while noninvasive techniques such as reflectance confocal

microscopy, optical coherence tomography (OCT), and line-field confocal optical coherence tomography (LC-OCT) may assist in tumor subtyping and margin delineation in specialized centers. Nevertheless, histopathology remains the gold standard, particularly for defining tumor subtype, depth, infiltrative pattern, and risk of recurrence. Cross-sectional imaging with computed tomography or magnetic resonance imaging is rarely required, except in extensive, recurrent lesions, those with ill-defined clinical margins, or when there is suspicion of invasion into cartilage, bone, the orbit, or deeper structures.

Regarding histological subtypes, the most common are nodular and superficial; however, from both oncologic and reconstructive perspectives, the aggressive variants are of particular importance, including micronodular, infiltrative, morpheaform, and basosquamous subtypes. Micronodular BCC is characterized by small tumor nests infiltrating the dermis with greater subclinical extension than is apparent on gross examination, which is associated with a higher frequency of positive margins and an increased risk of local recurrence. Surgical series and reviews have identified the micronodular subtype—especially when located on the nose—as one of the histological patterns most strongly associated with recurrence following conventional excision when margin control is inadequate.

This has direct implications for the case presented. Although the lesion measured approximately 1 cm clinically, its location on the nasal ala—within the so-called “facial H-zone”—and the histopathological diagnosis of an ulcerated, pigmented micronodular subtype classified it as a lesion of both high biological and anatomical risk. In such contexts, surgical planning must prioritize complete excision with adequate histological margin control over mere tissue preservation, as performing an aesthetic reconstruction over residual tumor tissue compromises oncologic outcomes and makes subsequent salvage procedures more challenging.

I. Surgical Treatment of Basal Cell Carcinoma. Surgery remains the treatment of choice for basal cell carcinoma (BCC) in many patients, as it offers the highest cure rates, allows histopathological assessment of margins, and simultaneously addresses both the oncologic and reconstructive aspects of the disease. For low-risk lesions, conventional excision with clinical margins of 3–4 mm is generally sufficient. In contrast, for high-risk tumors—defined by centrafacial location, recurrence, poorly defined borders, or aggressive histological subtypes such as micronodular BCC—current guidelines recommend Mohs micrographic surgery or, when this is not available, wider conventional excision with careful histopathological evaluation. Several European and North American guidelines suggest larger margins for high-risk lesions, typically ranging from ≥ 4 mm up to 5–10 mm, along with deeper excision extending to the fascia, perichondrium, or periosteum as appropriate. Mohs micrographic surgery is considered the

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gold standard for high-risk BCC of the face, particularly when aiming to achieve the optimal balance between oncologic control and preservation of healthy tissue. A systematic review and meta-analysis demonstrated lower recurrence rates with Mohs surgery compared to standard excision in both primary and recurrent facial BCC. Additionally, randomized studies with long-term follow-up support its superiority in selected facial lesions. However, Mohs surgery is not universally available in all centers. Therefore, wide three-dimensional excision with adequate clinical margins and formal histopathological assessment remains a valid and widely employed strategy in cutaneous oncologic surgery and reconstructive plastic surgery.

In the patient presented in this case, the decision to perform a wide three-dimensional excision with a 1 cm margin may be interpreted as a surgically prudent approach for three main reasons: (1) the lesion was located in the centrofacial region; (2) the histological subtype was micronodular, indicating aggressive behavior; and (3) the alar location necessitates anticipation of subclinical extension and poses challenges for potential reintervention.

Although a 1 cm margin may exceed what is commonly employed for many conventional facial BCCs, in a high-risk nasal lesion without availability or indication for Mohs surgery, such an approach may be justified as a strategy to maximize the likelihood of complete excision prior to reconstruction. In other words, in this scenario, oncologic radicality was prioritized, followed by reconstruction in a single surgical stage.

II. Non-surgical Treatment. Non-surgical options have a well-defined but more selective role in the management of basal cell carcinoma. Radiotherapy may be used in patients who are not surgical candidates, in locally advanced unresectable tumors, or as adjuvant therapy in selected cases. However, in nasal lesions and in relatively young patients, it is often less desirable due to long-term sequelae, skin changes, risk of radionecrosis, and the increased complexity of subsequent surgical salvage. Topical treatments such as imiquimod and 5-fluorouracil, as well as photodynamic therapy, are primarily useful in superficial BCC or highly selected lesions, but they are not the preferred option for aggressive subtypes or tumors with suspected deep extension. In cases of locally advanced or metastatic disease, Hedgehog pathway inhibitors such as vismodegib and sonidegib have significantly altered the therapeutic landscape and are now considered standard systemic treatments. Immunotherapy with anti-PD-1 agents is also being explored in refractory or advanced settings. In this context, the case presented clearly falls within the group of patients for whom surgery remains the optimal primary strategy, as it provides diagnostic certainty, effective oncologic control, the ability to assess margins, and immediate reconstruction using tissue with similar characteristics. This is particularly important in the nasal ala, where the goal is not only to close a defect but also

to preserve alar contour, maintain patency of the external nasal valve, ensure symmetry, and achieve harmonious integration with nasal subunits.

III. Historical Background and Principles of the Bilobed Flap. The bilobed flap was originally described by Esser in 1918 for nasal reconstruction. Decades later, Zitelli popularized its modern design by reducing the arc of rotation and optimizing tension distribution, thereby decreasing complications such as pincushioning and alar elevation. Currently, the bilobed flap is one of the most widely used techniques for the reconstruction of small to medium-sized cutaneous defects of the lower third of the nose, particularly involving the tip, supratip, and lateral nasal ala. From a classification standpoint, the bilobed flap is a local transposition flap with a random vascular pattern, composed of two lobes that share a common cutaneous-subcutaneous pedicle. Its principal advantage lies in its ability to redistribute tension toward areas of greater tissue laxity while reconstructing the defect with adjacent skin that provides excellent match in color, thickness, and texture—an aspect of particular importance in nasal reconstruction. Compared with simple advancement flaps or skin grafts, the bilobed flap offers superior chromatic integration and reduces the risk of patch-like aesthetic deformity. It consists of designing two contiguous lobes: the first lobe is used to cover the primary defect, while the second lobe closes the defect created by the first. The secondary defect resulting from the second lobe is typically closed primarily. This technique is primarily indicated for small to moderate defects of the distal third of the nose, generally ranging from 0.5 to 1.5 cm, when there is sufficient laxity of the adjacent skin and a single-stage reconstruction is desired, with minimal anatomical distortion and good aesthetic harmony based on nasal subunits. In the nasal ala, it can be used with favorable outcomes in selected defects, provided that the direction of tension vectors is carefully respected to avoid alar retraction or distortion of the external nasal valve.

IV. Surgical Technique: Practical Principles. From a technical standpoint, an initial assessment of the defect must be performed after confirmation of complete oncologic resection. In the modern classic design, the first lobe is positioned adjacent to the defect, while the second lobe is placed in an area of greater tissue laxity, with arcs of rotation smaller than the historical 180° designs. Typically, the first lobe is designed to be similar in size or slightly smaller than the primary defect, whereas the second lobe is usually somewhat smaller. Dissection should include skin and subcutaneous tissue in a plane that preserves vascular perfusion, with wide undermining to minimize tension. Meticulous hemostasis is essential, as is careful thinning of the flap when indicated, precise alignment of wound edges along natural creases, and deep fixation to prevent traction on the alar margin.

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V. Most Common Complications. The most frequently reported complications include trapdoor deformity (pincushioning), tissue redundancy, visible scarring, distortion of the alar margin, tip elevation, partial distal necrosis, venous congestion, wound dehiscence, and subunit asymmetry. In the nasal ala, improper planning of tension vectors may result in alar retraction or functional impairment of the external nasal valve. These complications can be minimized through appropriate flap design, limited rotation angles, wide undermining, meticulous hemostasis, and careful patient and case selection.

CONCLUSIONS

The case of this patient encapsulates several contemporary principles of facial cutaneous oncologic surgery. First, it involved a high-risk nasal basal cell carcinoma due to both its anatomical location and its micronodular histological subtype. Second, the procedure prioritized wide three-dimensional excision prior to any reconstructive intervention, which is consistent with the literature discouraging definitive reconstruction without adequate margin control. Third, once the defect was created, reconstruction with a bilobed flap represented a logical choice, as it allowed single-stage closure using adjacent tissue with appropriate skin quality while preserving the nasal contour. This approach aligns closely with the principles of oncologic reconstructive plastic surgery, where the goal is not merely to “close” a defect but to reconstruct the anatomical unit while maintaining oncologic radicality.

Basal cell carcinoma is the most common cutaneous malignancy; however, its seemingly low aggressiveness can be misleading in centrofacial lesions and in histological subtypes such as the micronodular variant, where subclinical extension and recurrence represent significant risks. In this context, surgery remains the treatment of choice, and in high-risk lesions, priority should be given to complete excision with adequate margin control. The bilobed flap retains its relevance as a highly valuable reconstructive option for nasal defects when they are small to moderate in size and when reliable functional and aesthetic outcomes are required. In the present patient, wide excision followed by reconstruction with a bilobed flap represents an approach fully consistent with contemporary principles of cutaneous oncology and facial reconstructive plastic surgery.

AUTHOR CONTRIBUTIONS

José David Rodríguez-Enríquez: conceptualization, project administration, supervision, writing – original draft, writing – review and editing. **Guillermo Tapia-Barragán:** formal analysis, resources, software, writing – review and editing. **Mauricio Alonso Espinosa-Romero:** investigation, methodology, resources. **Kevin Adrian Tinajero-Camacho:** investigation, methodology, resources. **Yuliet Guadalupe Sánchez-Javier:** investigation, methodology,

resources. **Rodrigo García-Zarco:** investigation, methodology, resources. **Diana Patricia Báez-Osorio:** investigation, methodology, resources. **Paul Alejandro Palacios-Zaragoza:** investigation, methodology, resources. **Martha Nahomi García-Sandoval:** investigation, methodology, resources. **Ilse Alejandra Olivares-Flores:** investigation, methodology, resources.

DECLARATION OF CONFLICT OF INTEREST

The author declares that he has no conflict of interest related to this article.

FUNDING DECLARATION

The study did not receive external financial support.

CONSENT

The patient provided written informed consent for the publication of this case report and any related images.

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