Introduction

The Supraclavicular Artery Island (SAI) flap is a regional fasciocutaneous flap which is raised from skin on the supraclavicular and shoulder area for reconstruction of head and neck defects. Mütter first reported the application of medial-based random shoulder flaps in 1842 [1]. In 1979, The supraclavicular artery flap was described by Lamberty as an axial flap [2]. Until the late 1990s, Pallua described a detailed anatomy of the blood supply to this flap [3]. In their study, the supraclavicular artery is a branch of the transverse cervical artery. The paired venae comitantes joint the transverse cervical vein or the external jugular vein. The origin of the flap artery is found in the triangle formed from the external jugular vein, the posterior border of the sternocleidomastoid muscle, and the clavicle. In 2009, Chiu applied the SAI flap to reconstruct the oncologic defects of the head and neck.

We have used the SAI flap for the head and neck defects after tumor ablation since 2012. The objectives of our study were to evaluate the advantages and disadvantages of the SAI flap in reconstruction of oral cavity defects.
- 27) (Figure 2), we de-epithelialized the proximal portion of the flap to fit the defect, medium skin paddle size was 51.2 cm² (range, 48 – 54). Harvest duration was 38.9 minutes (range, 30 - 45).

We had 6 patients (28%) with minor donor-site dehiscence, whereas larger dehiscence occurred in 2 patients (19%). The donor-site wound of these two patients requires prolonged wound care. We have no case in which severe limitations of arm movement was reported. We had 2 patients (19%) with partial skin flap necrosis, and one case (4.7%) with complete loss of the skin paddle. With total skin flap necrosis, in the case of total glossectomy, we have performed a second reconstructive procedure using pectoralis major flap.

Four patients of ours (16%) acquire the complication of salivary fistula, all of the fistulas recovered spontaneously. All of our patients have accepted rehabilitation of speech and swallowing capacity (Figure 3).

**Discussion**

Among the choices of head and neck reconstruction, microvascular free flap is the standard of operation, the radial forearm flap and anterolateral thigh flap are considered the workhorse flaps. Free-tissue transfer is very reliable and versatile but requires technical expertise and longer surgery duration.

Our initial experience with the SAI flap has revealed this flap to be available for reconstructing a variety of oral cavity defects.

Niels Kokot, et al. have found the SAI flap to be safe, versatile, easy to harvest, and reliable for the head and neck defects [4]. Jay W. Granzow et al have supposed this flap to be thin, pliable fasciocutaneous regional flap [4].

According to the research of Niels Kokot on 45 patients, there are 8 cases (18%) of partial skin flap necrosis and 2 cases (4%) of total flap necrosis [3]. Our research has 9.5% partial flap necrosis and 4.8% total necrosis. Our SAI flap sizes are similar to those of the other authors [5].

The SAI flap has a long pedicle, so this flap can reach most of the oral cavity defects [6–8]. However, in some cases of complex three-dimensional defects, the SAI flap showed some shortcomings because of the rotational nature of the flap. If we try to stretch the flap to cover the defect, the tension combined with the rotation at the flap pedicle may compromise the distal skin paddle.

**Conclusion**

The SAI flap is reliable and versatile in reconstruction of oncologic defects of oral cavity and may be an alternative for free-tissue transfer in selected patients. However, the SAI flap has some disadvantages because of its length and its rotational arc, so this flap is limited for some complex oral cavity defects.

**References**


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