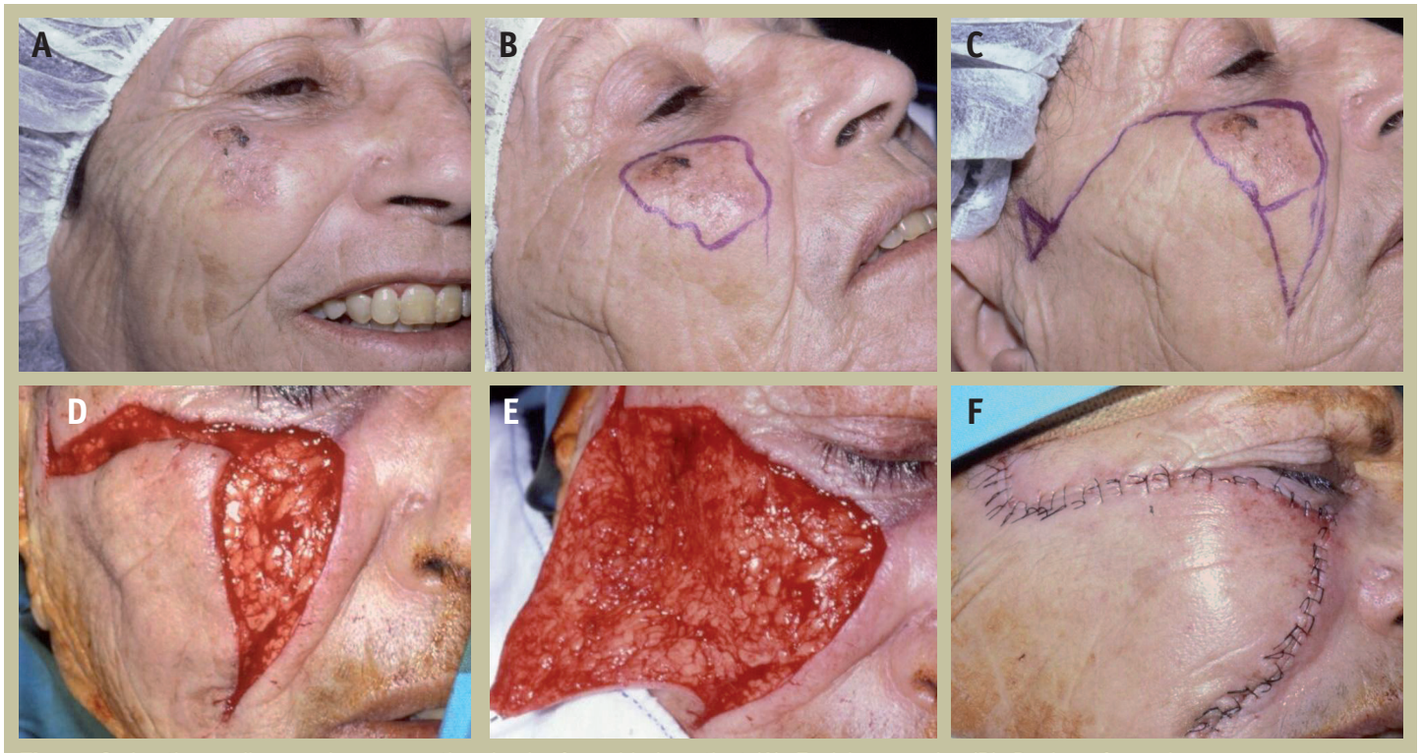

Figure 6. *Lentigo maligna melanoma on the cheek of an elderly patient (A). Excision margins (B). Design of an advancement-rotation flap on the cheek with incisions aligned with the RSTL and local wrinkles (C). Sculpting the flap (D,E). Final result with minimal tension due to skin laxity (F).*

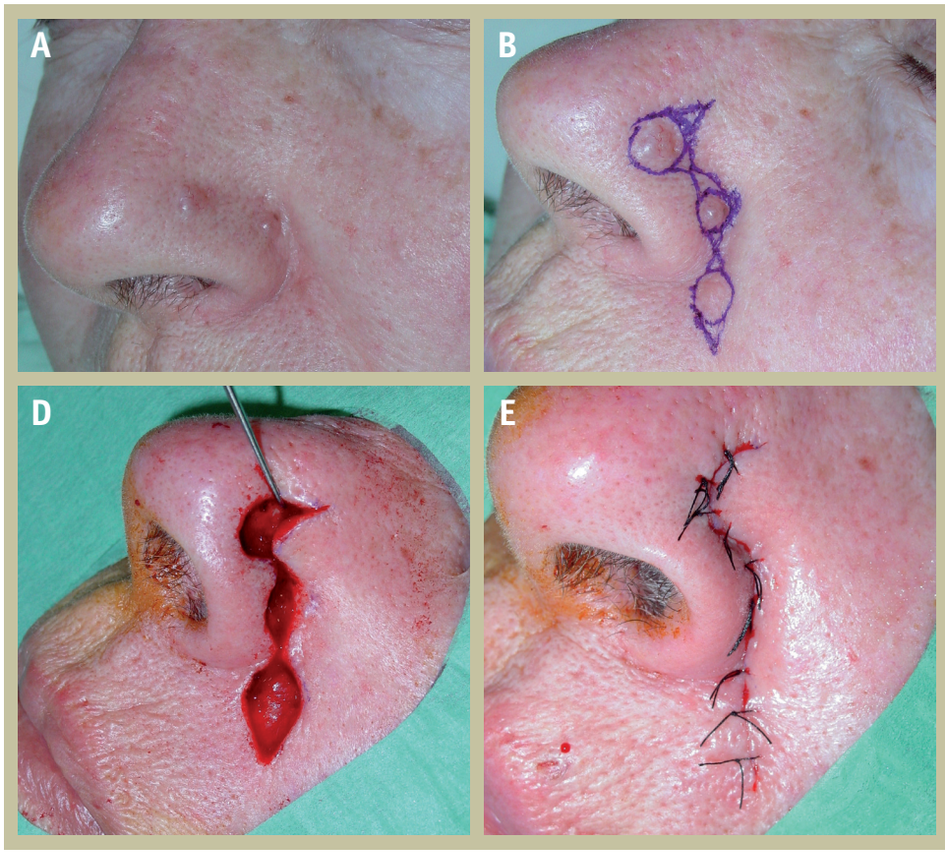

Figure 7. *Three adjacent basal cell carcinomas located on the nasal wing and nasogenian fold (A). Design of the excision and repair with small discharge triangles at the ends of the first and third lesion, following the natural folds (B). Final defect (C). Displacement with a dissecting hook to facilitate "step" closure (D). Final result (E).*

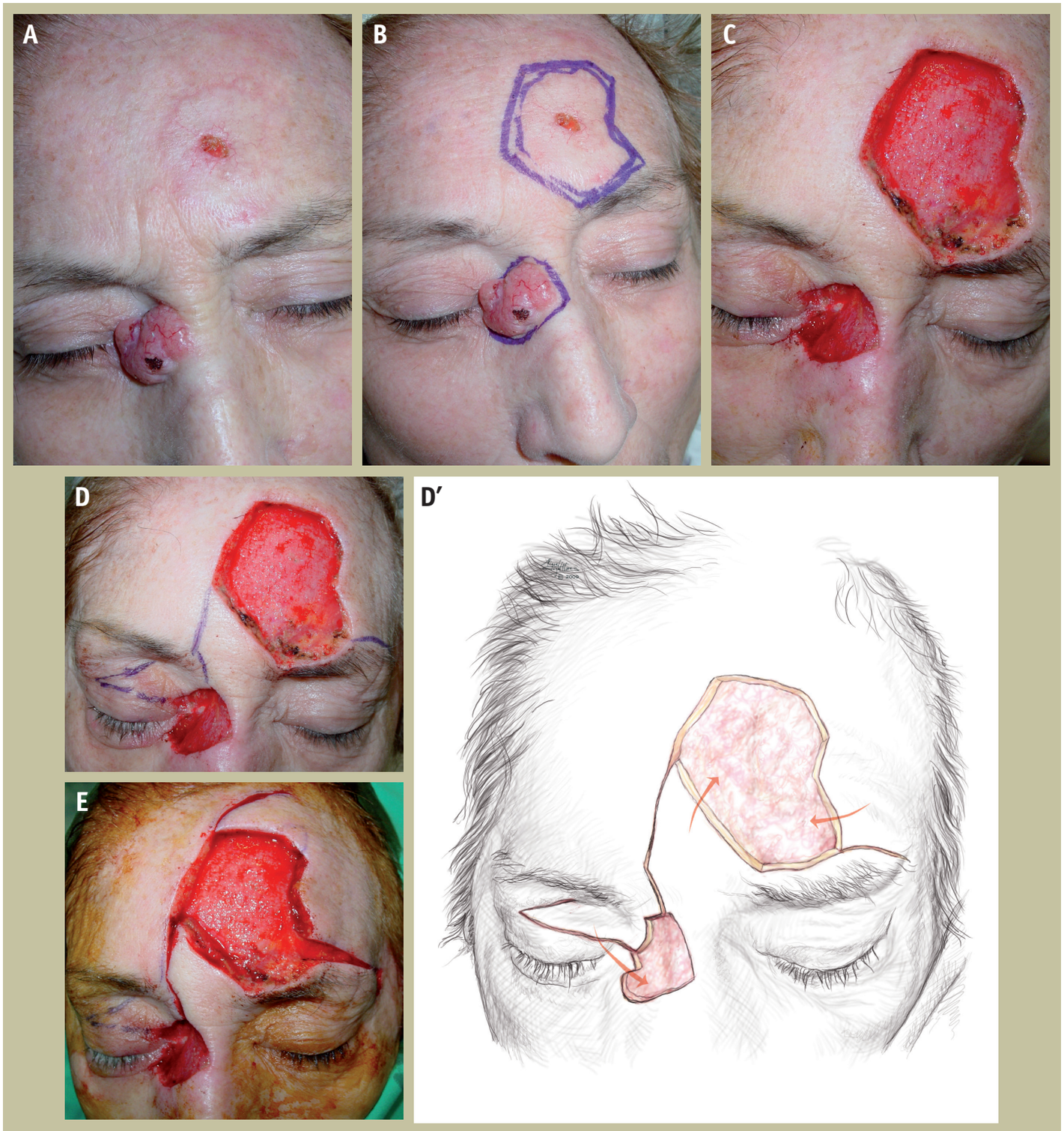

Figure 8. *Poorly demarcated ulcerated morpheaform basal cell carcinoma on the forehead and nodular basal cell carcinoma on the inner canthus (A). Excision margins for three-dimensional histology study (B). Final defects, with eyebrow drop due to denervation (C). Design of a transposition flap from the upper eyelid to close the canthus defect; rotation and advancement flaps to reconstruct the forehead (D,D′). Sculpting the flap, with additional incision towards the hairline (E).*

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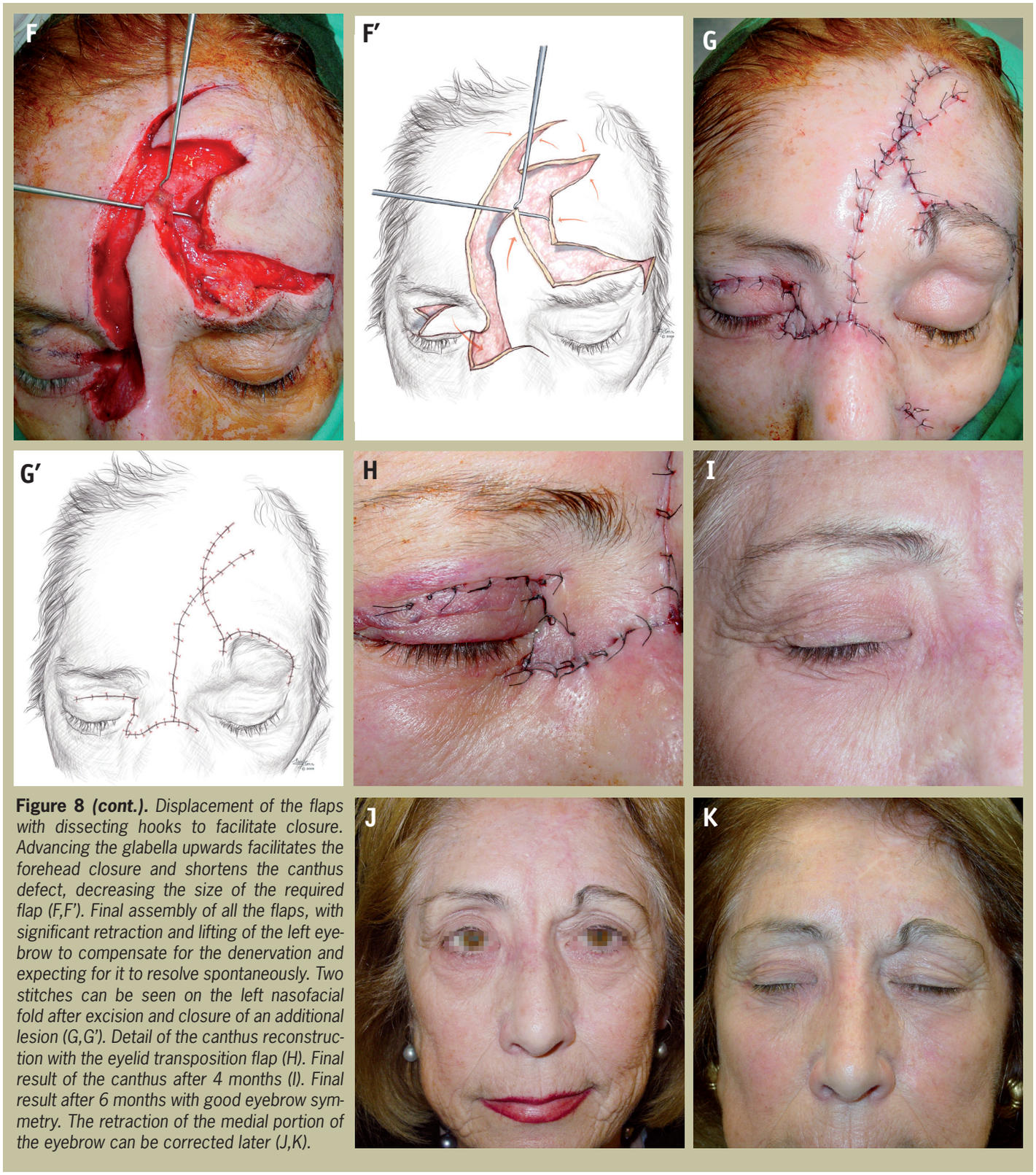

Figure 8 *(cont.)*. *Displacement of the flaps with dissecting hooks to facilitate closure. Advancing the glabella upwards facilitates the forehead closure and shortens the canthus defect, decreasing the size of the required flap (F,F′). Final assembly of all the flaps, with significant retraction and lifting of the left eyebrow to compensate for the denervation and expecting for it to resolve spontaneously. Two stitches can be seen on the left nasofacial fold after excision and closure of an additional lesion (G,G′). Detail of the canthus reconstruction with the eyelid transposition flap (H). Final result of the canthus after 4 months (I). Final result after 6 months with good eyebrow symmetry. The retraction of the medial portion of the eyebrow can be corrected later (J,K).*

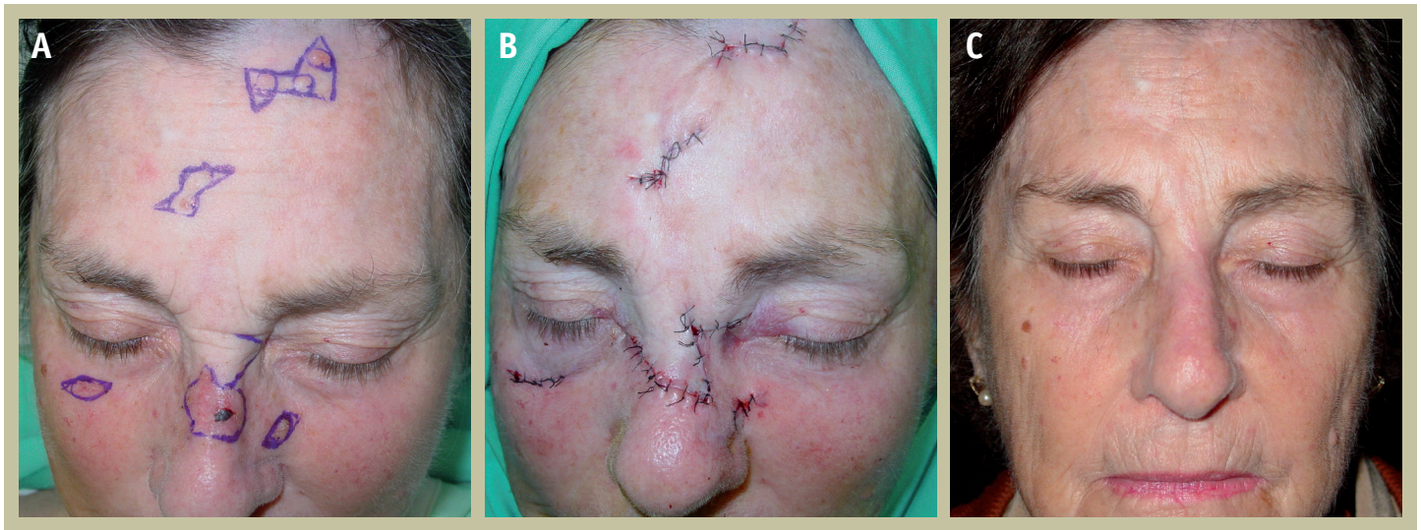

Figure 9. *Patient with multiple epithelial tumours on the face. Excision margins. Design of spindles and flaps for reconstruction (A). Immediate result, with slight skin retraction on the nasal dorsum (B). Final appearance after 6 months with a good aesthetic result (C).*

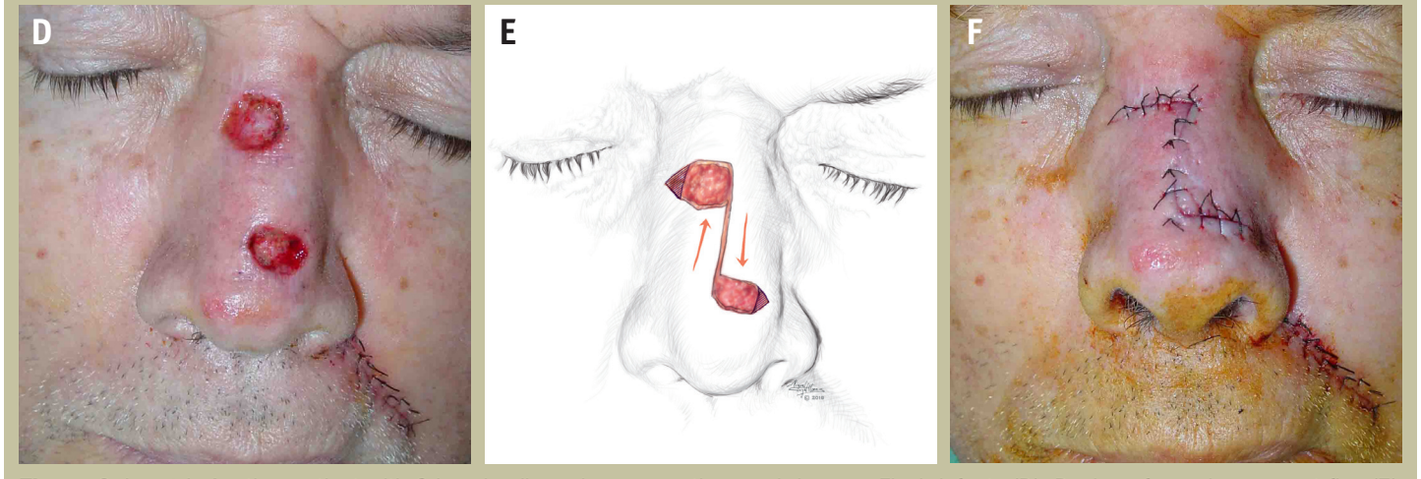

Figure 9 *(cont.)*. *Another patient with 2 basal cell carcinomas on the nasal dorsum. Final defects (D). Design of an advancement flap (E). Immediate result after layered closure (F).*

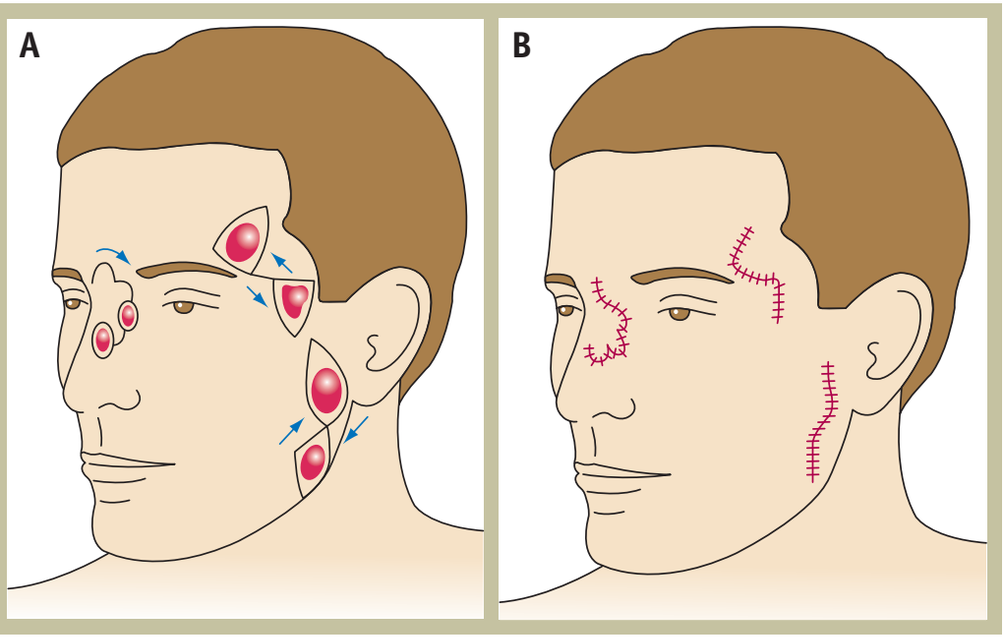

Figure 10. *Diagram of adjacent basal cell carcinomas on the temple, the masseter-parotid region, and the nasal sidewall. Design of 2 advancement flaps (temple and masseter) and one trilobed flap (nasal sidewall) (A). Final result (B).*

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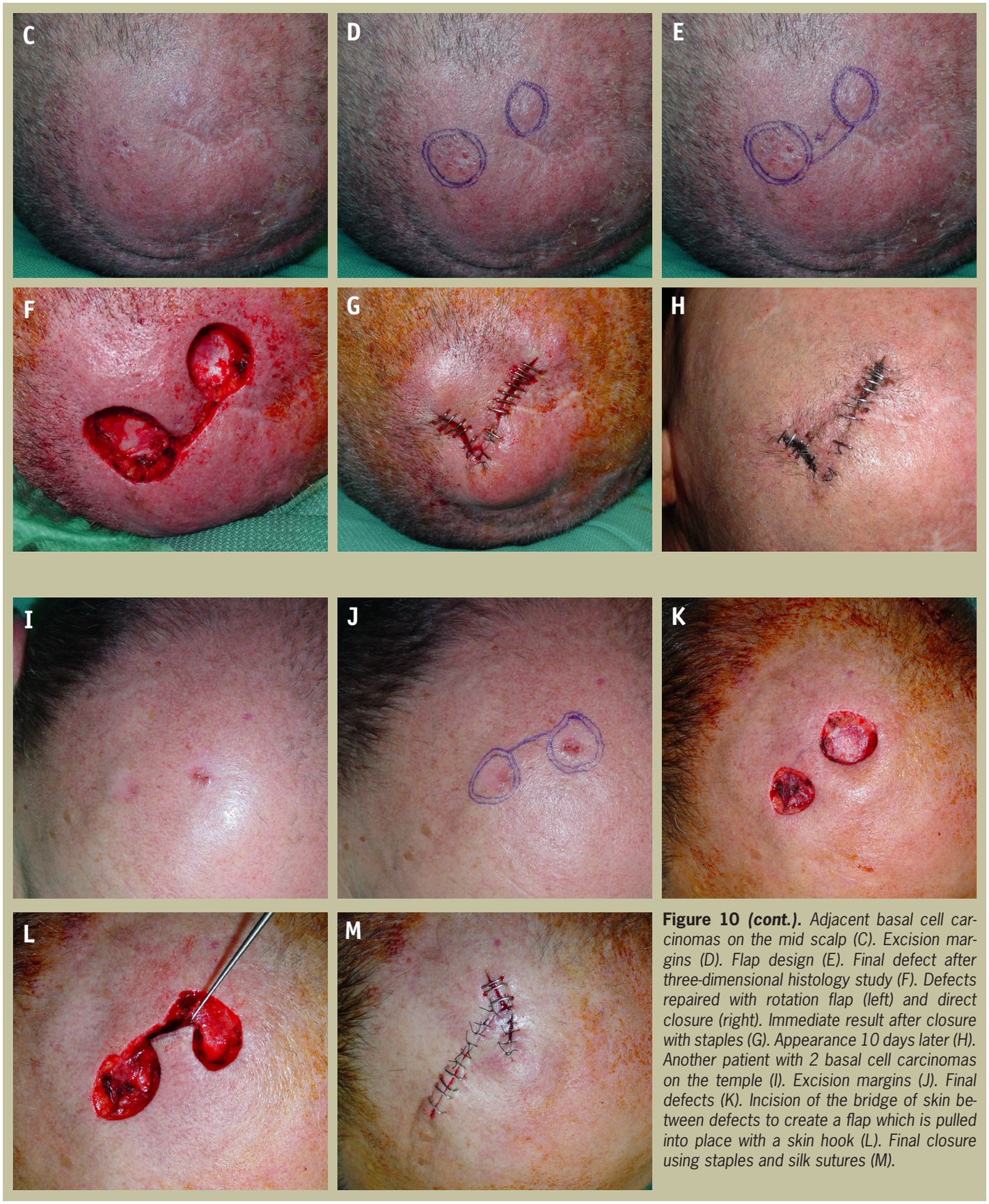

Figure 10 *(cont.)*. *Adjacent basal cell carcinomas on the mid scalp (C). Excision margins (D). Flap design (E). Final defect after three-dimensional histology study (F). Defects repaired with rotation flap (left) and direct closure (right). Immediate result after closure with staples (G). Appearance 10 days later (H). Another patient with 2 basal cell carcinomas on the temple (I). Excision margins (J). Final defects (K). Incision of the bridge of skin between defects to create a flap which is pulled into place with a skin hook (L). Final closure using staples and silk sutures (M).*