

CASE REPORT

RECONSTRUCTION OF MANDIBLE BY FREE FIBULA VASCULAR GRAFT AFTER TOTAL MANDIBULECTOMY: A CASE REPORT

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ABSTRACT: Reconstruction of mandible is important to provide good functional, and cosmetic result after Resection of the bony lesions involving large area of the mandible. The purpose of primary reconstruction is to avoid the collapse of maxilla-mandibular alignment due to scarring and fibrosis. Primary reconstruction by micro vascular bone grafting has been considered as the gold standard treatment option.^{1,2} The patients are rehabilitated functionally to minimize the functional disturbances thus the patient's psychological aspects as well as the quality of the life also improve. However local facilities for surgery, surgical morbidities, medically compromised condition of the patient, infection, cost and various other parameters may not often permit this. In this instance, reconstruction plate plays a major role as a preliminary option which avoids all the esthetic and functional deformities and further maintains a reasonable facial contour.^{3,4} Spontaneous bone regeneration in young individuals after segmental resection of mandible has been sporadically reported. This case reports spontaneous regeneration of the mandible in a 25 Year old Indian patient who underwent total mandibulectomy preserving the bilateral condyle and stabilized with indigenous, titanium plate for an extensive resection of Odontogenic keratocyst.

KEYWORDS: Mandibulectomy, Odontogenic keratocyst, Tibia vascular graft.

INTRODUCTION: Resection of the mandible and immediate reconstruction with autogenous bone graft are widely used in the treatment of odontogenic keratocyst involving a large section of the mandible. The purpose of reconstruction is mainly to rehabilitate the patient esthetically by improving the Contour of the mandible, thereby minimizing facial deformity from the defect. The patient is rehabilitated functionally and the occlusal disturbance is minimized.

Primary reconstruction by bone grafting is usually advocated at the time of surgery for various Reasons. The access to the surgical site is optimal because there is no fibrosis of the graft bed. However, local facilities for surgery, infection, and patients' general condition may not often permit this. Extensive bone regeneration that reconstitutes 50%.^{5,6} or greater than 50% of the mandible.⁷⁻¹⁰ after injury involving a segment of mandible have been reported previously. There is, however, no reported case in which a whole mandible regenerates with condyles. This study presents a rare case of spontaneous regeneration of a whole mandible in a 25 year-old Indian patient who had total mandibulectomy for an extensive case of odontogenic keratocyst.

Report of a Case: A 25 years-old boy reported to Oral and Maxillofacial Surgery Clinic complaining of slow growing Swelling over a left Jaw on both sides. Since, one and half years. On general examination patient was moderately built and moderately nourished. Local Examination: There was diffused boney hard swelling extending from right side ramus of mandible to the left side ramus of mandible. Intra orally there was expansion of cortical plate from ramus to ramus.

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The swelling gave an eggshell cracking sensation non-palpation.

Radiographic examination of the mandible showed multiple radiolucencies involving lower border of mandible from right ramus to left ramus. OPG reveals huge multiple radiolucency's involving lower border of mandible from right ramus to left ramus. An incisional biopsy was done with thorough curettage of the lesion under general anaesthesia biopsy report came as odontogenic keratocyst. Patient was planned for resection and reconstruction of the complete lower Jaw which was affected. Lesion Asymptomatic, circumscribed, radiolucent area associated with the unerupted mandibular right third molar.

Our Differential Diagnosis Includes: Dentigerous cyst, Keratocyst, Ameloblastoma, Ameloblastic fibroma, Odontogenic fibroma, Adenomatoid odontogenic tumor, Calcifying epithelial odontogenic tumor, Ameloblastic fibro-odontoma, and Calcifying odontogenic cyst.

This lesion turned out to be an odontogenic keratocyst arising from the cell rests of the dental lamina. These are commonly found in the 3rd molar region of the mandible.] They can be large and destructive and may present with pain or other symptoms.

Histologically, we see a lining of parakeratinized stratified squamous epithelium. The basal cell layer of the epithelium exhibits columnar nuclei that are palisaded or lined up like a picket fence.

Under general anesthesia with nasoendotracheal intubation GA was induced. Incision was made from right angle of mandible to the left angle of mandible. Bone was exposed and affected part was resected and titanium reconstruction plate was inserted and fixed to the right condyle to left condyle. Wound was closed in layers. Patient recovered uneventfully. Then the tissue was sent for the biopsy and report was odontogenic Kerotocyst. Patient was followed for three months for every fifteen days and regular OPG X-rays were taken to observe any recurrence of the lesion then after confirming there is no recurrence patient was taken up for another surgery and free tibia vascular graft was put. And patient recovered uneventfully. Further dental implants and complete oral rehabilitation is planned after one year.

DISCUSSION: New bone formation can take place though the process of osteogenesis osteo induction and Osteoconduction.¹¹ Periosteum plays a very important role in new bone formation and it is important to preserve it during surgery. There are reports that suggest even irradiated periosreum still has some osteogenic potential.

Ruggerio and Don off reported a case of spontaneous regeneration of the mandible after irradiation. The case described in this study supports the important role of periosteum in spontaneous regeneration. Spontaneous regeneration of a large portion of the mandible had been reported after subtotal mandibulectomy ot hemimandibulectomy. The factors favoring the new bone regeneration are age of the patients, preservation of the periosteum, absence of infection and decreased tension in the bone. Cases of spontaneous regeneration of the mandible reported in the literature are in young individuals with age range from 5 to 11.¹²

It is the author's assumption that the muscle forces act along the central long axis of the condyle, so that placing the reconstruction plate behind the condyle gives more stability for the condyle. All the regeneration techniques are affected by the bone area in which are carried out, ensuring that clinical outcome will be different by jaws area. In fact, blood supply of the grafted material is influenced by site-specific location of the overall bone marrow, which is more sensitive to regeneration because is more vascularised than the cortical one, less disposed to metabolic exchange.

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A key role in maintaining bone grafted volume is played, however, by the implant: its active surface is the basis of the metabolic exchange processes with bone cells and growth factors that ensure the functioning of the bone/implant/prosthesis system. Misch and Zarb have classified jaw bone density by dividing cortical and medullary quote in different portions of mandibular and maxillary bones. Therefore, bone type D1 (Cortical thick) is found in symphysis region; bone type D2 (Thick cortical bone and thick medullary bone) in mandibular ramus; bone type D3 (Thin and porous cortical bone and thin medullary bone) across the maxillary arch; bone type D4 (Thin and large trabeculae) in the tuber maxillae.

The possibility of integration of a graft material in addition to the density parameter depends on the morphology of the residual ridge. This morphology from a clinical point of view influences the depth of the vestibule, the tension of the flap and thus the stability of the material after the suture. The severe reabsorbed edentulous mandibular ridge has got all these characteristics in the negative, in contrast to the maxillary areas.^{12,13}

Anatomically than placing laterally. Immediate post-operative CT Radiographs also showed that the condyles were in normal anatomical position. Further studies are recommended to prove the authors assumption. It is well known that periosteum is a good source for bone formation. During resection the periosteum should be preserved if it is not involved with the lesion.¹⁴



Fig. 1: Extra Oral Swelling of Mandible

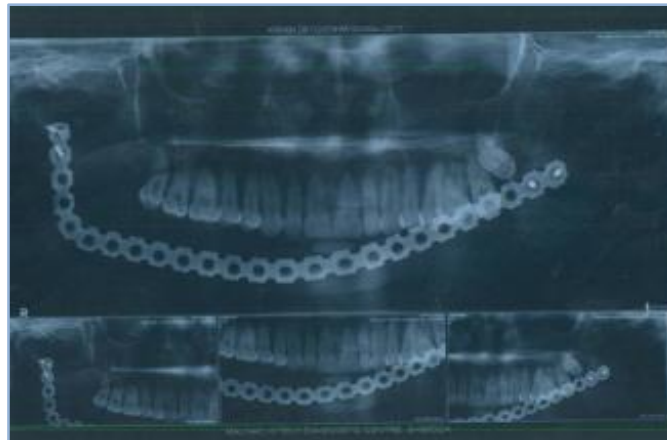
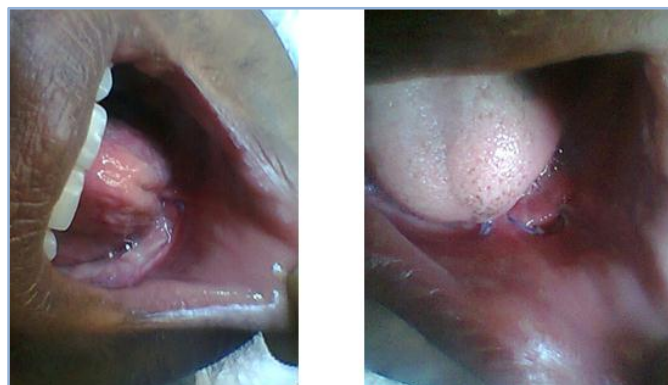


Fig. 2: After the Resection of the Mandible and fixing the Titanium Reconstruction Plate



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