arise in this study. It is to be noted that the present study not only looked at primary disease but also at radioresidual and recurrent disease, which are excluded in most studies examining mandibular invasion by various radiological techniques and may have high sensitivities. It is rightly mentioned in the letter that examination modalities have different sensitivities and specificities and that none of the modalities is 100% sensitive or specific; of these, bone SPECT has highest sensitivity, ranging from 90% to 97%. This means that if one relies on a single modality to diagnose bone invasion, there are chances of either missing the invasion or making an unnecessary sacrifice of mandible. The letter to editor puts a lot of emphasis on a study in which diagnostic algorithms have been proposed. The article states a 100% sensitivity for SPECT, i.e., all bone invasions were correctly identified; however, if one looks at the article closely, one will see that only 45 of the 44 histological mandibular involvements were identified by SPECT. The authors have reported the results of one bone SPECT and MRI to be uncertain; yet the sensitivity is calculated to be 100%, because this case had been excluded from the analysis, thus inflating the sensitivity of SPECT. In addition, the algorithms had been prepared using subgroup analysis of 43 bone invasion–positive patients only, and hence the number in each subgroup is very small and the power of the study is low.

The concept of periosteal stripping is not new and has been earlier reported by other authors including Dr Van Cann. In his study 5 patients who were negative for bone involvement by radiology underwent periosteal stripping on the table. As we concluded in our article, that is not an oncologically safe procedure and should be avoided; however, there are no data available on its safety. We are not able to provide evidence on the risk of periosteal stripping, as the study was not designed to answer this question.

We too have concluded that it is possible to identify nearly all cases of mandibular involvement by combining clinical examination, radiological examination, and grade of tumor. It is easy to identify direct cortical invasion or medullary invasion; however, invasion along the inferior alveolar nerve and mental nerve is difficult to diagnose, as the only features could be sensory disturbances without any evidence of radiological involvement of mandible. In the present study, 5 patients had involvement through the inferior alveolar nerve without destruction of mandible; these cases will prove difficult to diagnose preoperatively if one relies only on the results of imaging. Thus, we once again conclude from our results that a combination of clinical examination, radiological examination, and findings on periosteal stripping helps the surgeon to make an informed decision about preservation of mandibular continuity. The choice of reconstruction and the soft tissue loss are not affected by the decision to preserve mandibular continuity.

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References

THE USE OF BICHAT’S BUCCAL FAT PAD TO CLOSE OROANTRAL COMMUNICATIONS IN IRRADIATED MAXILLA

To the Editor:—I write in response to the article by Poeschl et al on the closure of oroantral communications using Bichat’s buccal fat pad flap in their series of patients. They have done a marvelous job of closing the defects, which can be difficult and large, and their results confirmed my personal experience on the viability of this flap. Likewise, I too irrigated the maxillary sinus before closure, except that chlorhexidine was used in my cases. In addition, I prescribed antibiotics (amoxicillin and metronidazole) to be taken 5 days before surgery and continue for another week postoperatively. This is done to ensure that there is no residual infection that may hinder the healing of the flap. I wonder whether Poeschl et al prescribe any antibiotics at all, and if so, what is the regimen used?

I note that because Poeschl et al were able to achieve excellent results even in osteonecrotic defects, they suggested that it is worthwhile to use this flap for small tumor-related defects in previously irradiated patients. However, I beg to differ and would caution against the use of this flap.
in irradiated maxillas. Please allow me to share my experience and reasoning for this worry.

I see lots of irradiated patients at our center as a result of treatment for nasopharyngeal carcinoma. On one occasion, an oroantral communication (5 mm in diameter) was created in one of these patients after the removal of 2 carious roots of the upper left molar tooth. The first attempt to close the defect—by use of a standard buccal sliding flap—failed, after which a Bichat’s buccal fat pad flap was used. Unfortunately, this also failed. In hindsight, this failure stemmed from undiagnosed osteoradionecrosis of the maxilla. A few years earlier, the patient’s upper left third molar even dropped off by itself, most likely because of osteoradionecrosis. Hence the action of removing the infected roots inflicted more trauma and resulted in an oroantral defect. The defect was closed with an obturator after the patient refused to undergo hyperbaric oxygen therapy and further surgery.

Besides this failure, the patient also received a scare from the consultant otorhinolaryngologist who treated him when he went for a follow-up not too long after the attempt to close the defect with a Bichat’s buccal fat pad flap. The otorhinolaryngologist, who had never seen a Bichat’s buccal flap, thought there were recurrences growing through the maxilla and the cheek area upon seeing this flap!

Lessons learned from this experience were as follows:

1. The use of hyperbaric oxygen therapy before closure with a Bichat’s fat pad flap on the second attempt may have altered the course of outcome.
2. There is a need to inform other health care workers (eg, dentists and otorhinolaryngologist/head and neck surgeons) about the presence of Bichat’s buccal flap as an exposed entity.

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Reference


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MANAGEMENT OF THE ALVEOLAR ANTRAL ARTERY DURING SINUS FLOOR AUGMENTATION PROCEDURES

To the Editor—Maxillary sinus floor lift surgery is a relatively recent technique that allows extending implant treatment to patients with extremely atrophic posterior maxilla. Despite the high level of predictability of such a surgical technique, vascular complications can develop that may compromise the outcome of the surgical procedure.

Because of its location, the intraosseous anastomosis between the posterior superior alveolar artery and the infraorbital artery, known as the alveolar antral artery, has the potential to cause bleeding complications during lateral window osteotomies.

Such an anastomosis has been reported in the width of the cortical bone of the lateral wall of the maxillary sinus only a few millimeters from the apices of the premolars and molars in 100% of cases. The alveolar antral artery, the dental branch of the posterior superior alveolar artery, courses intraosseously halfway up the lateral sinus wall and anastomoses with the infraorbital artery in correspondence with the anterior wall of the sinus.

Such an anastomotic circle, whose reported diameter is up to 2.5 mm, guarantees the hematic contribution to the sinus membrane, to perioistial tissues, and to the anterolateral wall of the sinus.

Although excision of this artery is not threatening because the hemorrhage mostly resolves due to a reactive contraction, impairment in visualization of the Schneiderian membrane may occur, making its elevation more difficult and interfering with placement of graft material, especially when its diameter is larger than 2 mm.

We believe that maintenance of such an anastomosis is important to support bone graft neoangiogenesis; in this perspective, its concomitant reflection with the Schneiderian membrane during sinus augmentation procedures should be considered.

Considering that electrocautery is to be avoided because of the risk of sinus membrane perforation, we also recommend the precautionary use of two 0.10-mm vascular mini-clamps with a closing pressure of 30 g (Aesculap Vascular Instruments, Tuttingen, Germany) before removing microvascular clips left in situ, in this way avoiding intense bleeding that may obscure vision and cause potential membrane perforation.

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IN REGARD TO DELAYED PARESTHESIA OF INFERIOR ALVEOLAR NERVE AFTER EXTRACTION OF MANDIBULAR THIRD MOLAR

To the Editor—In their report, the authors state that the patient had been drinking and “dancing like crazy” 8 days after the mandibular third molar removal. Should “drinking”...