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of the surgical field is significantly increased, insertion of the mouth-prop is uninhibited, positioning of the tongue retractor is made easier and it is not necessary to move the LMA when undertaking bilateral procedures in posterior region of the mouth. This poster illustrates this technique with text and images, explaining step by step the positioning and fixation of the LMA.

**P.088 Security device for a better control of impacted third molars during exodontia: A new technique**

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**Introduction:** Accidental displacement of impacted third molars, either a root fragment, the crown or the entire tooth, is a complication that occasionally occurs during exodontia. When the molar moves to maxillary sinus the problem is not as serious as when it gets into pterygomandibular or infratemporal spaces. The surgical procedure for the retrieval of such a displaced tooth may be complex due to poor visibility and limited space. However, serious disadvantages have been reported in the location of accidentally displaced third molars to this region. We describe an easy technique for a better control of non-erupted mandibular third molars during exodontia.

**Material and Method:** The instrument consists of the anchoring devices normally used to fix tendons and muscles, but in this case it is fixed into the relevant tooth.

Once the vestibular/occlusal faces of the molar have been sufficiently exposed, a drill is used to make a cavity that will act as a shroud enabling us to install our anchorage accurately. The anchorage supports a surgical thread which acts as a guide and/or a traction system to locate and/or extract the luxated molar more easily towards the sinus or the subtemporal fossa.

**Discussion and Conclusions:** Providing maximum safety and guarantee of success to the patient in any surgical procedure is an obligation. At the same time the surgeon benefits with a reduction in stress.

Moreover, the displacement of non-erupted molars is repeatedly referred to in the literature, and surgical procedures for their retrieval may be very complex, especially if the molar gets into pterygomandibular space or infratemporal fossa.

## Distraction

**P.089 The application of low-intensity-pulsed ultrasound stimulation to accelerate bony maturation in the alveolar ridge**

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The overall goal of this project is to establish the clinically optimal regimen of low-intensity pulsed ultrasound (LIPUS) stimulation to accelerate the bony maturation of distracted zone in the alveolar ridge. As the first step, we are planning an animal experiment to investigate the effects of LIPUS stimulation on bony maturation in the distracted alveolar ridge.

**P.090 The effect of compressive-distractive osteogenesis on dental pulp sensitivity in children**

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Dental pulp sensitivity was evaluated by means of electrodiagnostics (ED) in 10 children from 12 to 16 years.

Five patients with hemifacial microsomia and two children with acquired lower and upper jaw hypoplasia underwent lower jaw osteotomy and upper jaw Le Fort I osteotomy followed by distraction device fixation. Three children underwent bilateral osteotomy of the lower jaw with distraction device fixation. The ED was performed only in intact teeth pre-operatively, before distraction, after 10 days of distraction, at the end of distraction period and monthly during retention period.

It was found that intact teeth preoperatively had sensitivity threshold of 3-15 mV. Before distraction the value in all teeth was equal to 60-70 mV. In three patients the sensitivity threshold of central incisors on affected side was 180 mV and 2 children showed sensitivity threshold of the first and second upper molars on affected side to be 200 mV. The values stayed on the same level on the 10th day of distraction. At the end of distraction period the sensitivity threshold was 40-50 mV. By the end of the first month of retention the values continued to decrease and reached the preoperative figures by the end of the second beginning of the third month of retention.

Our evaluations revealed that compressive-distraction osteogenesis in children with congenital and acquired hypoplasia of the jaws leads to severe changes in sensitivity of teeth pulp. The changes are temporary and the sensitivity values return to normal rate by the end of retention period.

**P.091 Diagnostics and treatment of patients with zygomatico-maxillary-orbital fracture - Practical application**

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**Purpose:** The aim of this study is an evaluation of practical application of the classification of the upper part of facial skeletal fractures.

**Material and Methods:** Study is based on clinical and radiological data of 1060 patients treated at the 2nd Department of Maxillofacial Surgery between 1990 and 2004 due to zygomatico-orbital fractures (ZOF) and zygomatico-maxillary-orbital fractures (ZMOF).

On the basis of analysis of obtained results the clinical image of the type of fractures supplemented by radiological imaging that consists of standard X-rays for patients with ZOF and broadened to include computer tomography for patients with ZMOF defines the means of management.

**Results:** In the analysed clinical material patients with ZOF were treated surgically by direct methods: repositioning and fixation under visual control by use of mini or microplates. The simple indirect method of transcutaneous repositioning of bones with a hook was used in treatment of patients with ZOF containing one fragment of fractured bone in appropriately selected cases only.

**Conclusion:** Simultaneous reconstruction of the bone edges and the walls of the orbit together with orbital hernia reduction and reconstruction of post-traumatic bone lesions using autografts is

nd, it is months after surgery. Radiolucency was computer analysed using gray level histograms.

ly. Once Results: The analysis of the post-operative radiographs showed a somewhat higher bone density in the control group immediately post-operative and after 6 months; after 3 months the bone density in the test group was little higher. In the images after 12 months there was a clear difference in bone density with higher values in the test group compared to the preoperative grey levels. There was no statistical significance.

will be Conclusion: These results advocate for the clinical application of tissue-engineered bone as an alternative viable filling material for cysts.

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### P.180 Sialolithotomy with sialodochoplasty using surgical microscope for submandibular salivary gland

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**Introduction and Objectives:** Recently, for the treatment of sialolithiasis, non-surgical removal methods of sialoliths using basket catheters with sialoendoscopy have been performed aiming for the preservation of gland. We have found that these methods have a limited application in the removal of salivary calculi. We present a method developed to perform sialodochoplasty following removal of salivary calculus and report its clinical application.

**Material and Methods:** Between March and October 2005, three patients aged 55, 46 and 23 years with sialolithiasis in the transitional zone between the submandibular gland and the duct were seen in our clinic.

The invasiveness of our method was limited to submandibular approach with an incision of the skin and platysma. After retraction of anterior belly of diaphragm muscle, hypoglossal nerve and associated veins were identified and retracted. Then, submandibular gland was lifted upward to visualize the duct with the sialolith which was removed with less than 1 cm incision on the duct.

Finally sialodochoplasty was performed using a 9-0 nylon under surgical microscope to improve the precision.

**Results:** All three patients had uneventful recovery and had minimal post-operative symptoms. They could take the usual meal post-operatively on the same day. Good outflow of saliva from sublingual caruncula was observed post-operatively.

**Conclusions:** A method of Sialolithotomy with sialodochoplasty under surgical microscope at the transitional zone between submandibular gland and duct with preservation of the gland is reported.

### P.181 Submental intubation under fibroscope – A new technique

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**Introduction:** The technique is similar in anaesthetic preparation to that of nasotracheal intubation under fibroscope, with the difference that in the submental way the fibroscope, with the ring tracheal tube goes through the tunnel designed in the submental area under local anaesthesia.

**Material and Method:** We use conventional bronchoscopy fibrosopes and ring tubes (Rüschelitz® Tracheal Tube), which now can be of adequate calibre as those used for conventional orotracheal intubation, with resulting advantage, mainly for post-operative period and the units of reanimation and intensive care.

First, disinfections, asepsis and drawing of submental incision line take place. Followed, through a percutaneous way, by local anaesthesia of the area, from skin to subcutaneous tissue in infra and supra milohyoid space towards the floor of the mouth.

The skin is incised and subperiosteal tunnel designed. With the help of a rhinoscope to support it with the aim of allowing the ring tracheal tube inserted in the fibroscope to pass together through it, from the skin to the floor of the mouth, and reach, first with the fibroscope, the supraglottic space, introducing it in the laryngotracheal space, until glancing carine, all with adequate anaesthetic induction and relaxation, to slip ring tracheal tube to its laryngotracheal location.

**Discussion:** With this procedure we avoid transposition of the orotracheal tube to the submental space, this is, from a septic cavity to a sterile surface, besides the advantage of not having to release the endotracheal tube connection.

## Oral cancer

### P.182 Schwannoma of the inferior alveolar nerve

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Schwannomas (neurilemmomas) are benign tumours that originate from the Schwann cells. Their growth is slow, displacing nerve without invading it. It occur between 20 and 40 years, no gender inclination. Schwannomas could be painful (when presses the nerve) and produces paresthesias. Its therapy is surgery and, if we can remove completely, it will not come back. There is a malign type that needs radiotherapy after surgery.

**Case report:** A 36-year-old man was referred urgently by his dentist because left mandible pain during the last 2 weeks, with paresthesias around chin zone. There was no previous illness, drugs or allergic problems. The clinical examination showed a slight left buccal mandibular expansion, 3 cm in diameter, not much painful when pressed, and there was no inflammatory signs. The panoramic radiograph revealed a unilocular radiolucent lesion, from #37 to #34, with #35 root resorption. #36 was previously removed because caries 2 years ago. It was a well-circumscribed lesion, and its borders seemed to follow the limits of the inferior alveolar conduct. We suspected that it could not be a cystic lesion and decided to take a biopsy under local anaesthesia for having an histological exam. The diagnosis was benign schwannoma.

**Discussion:** Schwannomas therapy is surgery. The complete removing avoids recurrence. The intramandibular location make difficult the complete resection if we try to conserve the inferior alveolar nerve. Shall we respect the inferior alveolar nerve with some risk of recurrence? Shall we resect the inferior alveolar nerve with the tumour to evite recurrence?