Virtual planning of extensive jaw reconstructions

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Surgery is still the essential component of curative therapy of malignant neoplasms of oral cavity. The resection with sufficient safety margins has an immediate impact on the prognosis. Therefore, a partial resection of the jaw is often required. In contrast to the upper jaw defects, which can be treated non-surgically with individual prosthetics and obturators, continuity defects of the lower jaw cause massive restrictions of swallowing, communication and the external appearance. Nowadays, extensive defects are covered in many cases using microsurgical grafts. The extension of the accompanying soft tissue deficit influences the selection of the donor region. The microvascular fibula graft has become the "working horse" in many departments all over the world, when it comes to reconstruction of the mandible, it can be transplanted with or without a skin island and separated in several segments. Advantages of this bone containing flap in particular are a reliable anatomy at the donor site with few variances containing flap in particular are a reliable anatomy at the donor site with few variances when it comes to reconstruction of the mandible, it can be transplanted with or without a skin island and separated in several segments. Advantages of this bone containing flap in particular are a reliable anatomy at the donor site with few variances.

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The clinical and angiographic findings and lines are defined. Besides, the positioning of the vascular pedicle and the side of the microsurgical vessel anastomosis in the neck will be defined. After the virtual resection of the jaw, the segmentation of the bone transplant can be transferred from the virtual planning into the OR by the surgeon using prefabricated templates.

Now the production of the surgical resection templates for the facial bone and osteotomy templates for the bone transplant takes place. After the production procedure, a 3D stereolithographic model of the postoperative situation (after insertion of the fibula), templates for the osteotomies of the flap and for the tumor resection will be available in the OR. With the help of the 3D model, a 2.5 locking reconstruction plate is manufactured (Synthes, Oberdorf, Switzerland), which is precisely adapted to the postoperative, virtually planned situation.

Intraoperatively, the mandible is surgically exposed so that the resection templates can be positioned to allow performing

face contains a planning phase, a production phase and the operation phase.

The planning phase begins with acquiring a defect-related, high-resolution, axial scan of the facial skeleton. This can be performed using a conventional CT or a cone-beam CT (thus minimizing exposure to radiation). When malignant disease is present, the CT of the head and neck, which is necessary in respect of tumour staging, can be used for the planning. In addition, a high-resolution scan of the donor region is required – e.g. the lower leg – which should be combined with an angiography to exclude vessel anomalies. The received data are made anonymous and sent online to the processing company (Materialise (Leuven, Belgium)) via password-protected ftp server. The company then produces a virtual 3D model of both the defect (face) and the transplant donor site (fibula). Now with these data, a web meeting with the engineers of the company and the treating surgeons takes place. In this meeting the resection margins are defined, the segmentation of the bone transplant is discussed and the osteotomy lines are defined. Besides, the positioning of the vascular pedicle and the side of the microsurgical vessel anastomosis in the neck will be defined. After the virtual resection of the jaw, the segmentation of the bone transplant can be carried out and positioned virtually into the defect of the mandible. The clinical and angiographic findings and the defect size determine whether the graft is taken from the right or left lower leg. The planned resection and osteotomies of the bone transplant can be transferred from the virtual planning into the OR by the surgeon using prefabricated templates.

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the planned resection. They create a well-defined osteotomy plane. Generally, harvesting of the bone flap (e.g. fibula) is carried out simultaneously through a second team. Harvesting the fibula is performed after exposing the bone in the conventional manner, then fixing the osteotomy templates in the bone with screws. The template as a surgical guide defines the osteotomies which can be performed exactly on the predetermined lines. The individual reconstruction plate can be fixed to the fibula with the flap still perfused on the leg which reduces the time of ischemia. After harvesting the microvascular fibula graft, the surgeon positions the transplant into the bony defect of the mandible. The microvascular anastomosis is then performed in the neck vessels. Postoperative 3D cone-beam imaging allows the fusion of pre- and postoperative data and is later used for the planning of the dental implants.

Case presentation

In August 2010, a 30-year-old female patient was admitted to our department with a histopathologically proven chondroblastic osteosarcoma of the left anterior mandible. The clinical and radiological staging including CT-scans of the head and neck, thorax and abdomen were able to confirm the absence of second malignancies including the soft tissue of the chin with the use of PET-scans. The histological examination revealed a malignant giant cell tumor of the jawbone. The diagnosis was confirmed with an MRI scan of the brain and a biopsy of the mandible. The patient then underwent a resection of the tumour. For this, a lateral mandibulectomy was performed utilising the CAD/CAM planning technique. A CT-scan was acquired of the head and neck area as a re-staging diagnostic measure and to determine the current bone situation as a basis for the planning. In the planning session it was defined to use the left fibula and segment it into 5 segments to mimick the mandible arch. The operation was performed in two teams, the osteomicrosurgical fibula flap was harvested and osteotomised according to the pre-surgical plan using the osteotomy templates, the pre-bent 2.0 reconstruction plate was fixated to the fibula before ligating the vessels and then the flap was transferred as the neo-mandible to the head of the patient and fixation was finished with screws to the bilateral ascending ramus (Synthes, Oberdorf, Switzerland). The anastomosis was performed to the right facial vessels, the skin island was used to reconstruct the tissues of the floor of the mouth (Figure 1). After the operation, the patient was transferred to the immediate care unit and was then finally discharged from the hospital 10 days after surgery.

Following the reconstruction operation, some minor surgical procedures were carried out to optimise the appearance of the chin and realise the dental rehabilitation using implants. A removable denture was customised on an individual bar based on 6 implants (diameter of 4.1 mm and the length of 11.5 mm (BEGO Implant Systems, Bremen, Germany)) was fixed 9 months after the reconstruction procedure (Figure 2).

Conclusion

A good functional rehabilitation and the best possible aesthetic result after reconstruction of extensive jaw defects are of great importance for the patient. The method of virtual planning of jaw resection and reconstruction, which is introduced here, leads reliably to predictable reconstruction results and simplifies the operation process considerably. We have applied this procedure since April 2011 up to now with 52 patients successfully and have established this as a routine workflow in our department.

References


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