

Letter to the Editor

Shifting paradigm from just treatment to total maxillofacial rehabilitation

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Dear Editor,

We read with great enthusiasm an article entitled “Gorham disease of mandible treated with postoperative radiotherapy.”^[1] The treatment executed by Gupta *et al.*,^[1] is commendable and in accordance with the standard practice guidelines adopted by most of the institutions worldwide. However, in our opinion, today is an era of rehabilitation and not just treatment. The recognition of the multidimensional impact of maxillofacial pathologies on a patient’s life along with advances in surgical and prosthetic techniques, has led to an increased interest in improving the quality of life of these patients; which is possible only when we rehabilitate the patients in all aspects of health that are physical, functional, esthetic, psychological, and social.

After treatment of an active disease, two usually less heeded areas are rehabilitation and follow-up; both of which have profound effect on the prognosis and quality of life of the patient. Although the mandibular reconstruction has been done by Gupta *et al.*,^[1] with a reconstruction plate and condylar plate, yet the goals of mandibular reconstruction have not been achieved. The goals of mandible reconstruction are: Establishment of mandible continuity, establishment of an ossealveolar base, correction of adjacent soft tissue defects, and it has to provide sufficient durability and strength to allow resumption of daily activities.^[2] Hence, there is an indispensable need of second stage surgery where microvascularized osteomyocutaneous grafts should be used for mandibular reconstruction and then fabrication of mandibular prosthesis either conventional or implant retained; to rehabilitate the patient in the true sense.

Gupta *et al.*^[1] have rightly said that surgical reconstruction should not be done in active phase of Gorham disease due to risk of lyses of autologous bone graft, but it would have been appreciable if they would have mentioned that following the treatment of this notorious active disease and follow of at least 6 months after completion of radiotherapy (to reduce risk of osteoradionecrosis), secondary reconstruction with bone graft, preferable fibular bone graft, should be done to restore the form of lower third of face and to resume the mandibular functions.

Depending upon the defect characteristics, the surgeon can make choice of the most feasible and useful bone graft among the various options such as allogeneous (block grafts) or autogenous grafts (fibula and iliac crest). The fibula is an ideal bone for mandibular reconstruction, popularizing it as the workhorse for mandibular reconstruction.^[3] The distinct advantages of fibula are decreased donor site morbidity, the great length of bone that is possible (25-30 cm), possibility of doing multiple osteotomies for three-dimensional conformation, the high density preserving a great resistance to the forces of mastication and bicortical stabilization, which makes it ideal for placement of implants.^[4]

Surgical, radiotherapeutic, and prosthodontic rehabilitation of the mandibulectomy patient has the potential of being extremely gratifying to the clinician as well as making an enormous impact on the quality of life of the patient. The microvascularized free flaps and endosseous implants have revolutionized the way of treatment of such patients. In the future, we hope that the existing loopholes in the multidisciplinary treatment approach required for rehabilitation of patients with such complex defects, will be identified and rectified, so as to recuperate the patient to the best possible extent.

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