Gemeinsam mit Ihnen

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SECONDARY RECONSTRUCTION OF INTRA- AND EXTRAORAL SOFT TISSUE AND BONY DEFECTS

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In malignancies of the maxillofacial region, healing is often only possible on the basis of radical surgery with resection and sacrifice of large section of the jaw and the covering soft tissues. It is to be borne in mind that the buccal cavity is integrated in vital function such as mastication and degiutition, breathing and speech. Advances in maxillofacial surgery could clarify many questions involved in the reconstruction of soft tissues of the face, the bones of the visceral cranium bearing these structures and in the reconstruction of extensive buccal mucosal defects. From 1985 - 1990, secondary reconstruction of intra- and extraoral soft tissues as well as bony structures of the facial skeleton were performed at our department in 25 patients. Free bone grafts together with microvascular anastomosed jejunal flaps (11 patients), scapula grafts (7 patients 5-year survival rate 48.9%) and microvascular bone grafts from the iliac crest (7 patients) were used in combination with osteointegrated implants. Our results demonstrate that bone resorption in osteoplastic reconstruction techniques of jaw bones in combination with implants is limited (0.2 mm/year) compared to conventional free bone grafts. Besides that the almost complete restoration of masticatory-, speech and swallowing functions justifies the immense surgical expense of reconstruction techniques applied.

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NEOADJUVANT RADIOCHEMOTHERAPY IN LOCOREGIONALLY ADVANCED BREAST CANCER FOLLOWED BY SALVAGE MASTECTOMY AND RECONSTRUCTION

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Thirty-eigth patients with locally advanced inoperable breast cancer were treated by a combination of chemotherapy with mitoxantrone (4 courses 12mg/m^2) and simultaneous radiation.The group consisted of patients with primary tumours >5 cm,or T4-tumours (inflammatory carcinoma).Radiotherapy was performed by individual computerized treatment planning.The total target volume dose was 50-60 Gy.All patients underwent salvage Mastectomy four to eight weeks after completing radiochemotherapy.In 20 of 32 patients with clinical complette Remission (cCR),the CR's were pathologically confirmed(pCR),and in 12 patients only microscopic residual disease was found in the resection material.In the six patients with a cPR, the tumour was down-staged to operable disease.
Twelve women had immediate reconstruction using a TRAM-flap,16 patients received TEL and 6 patiemts LAT-flap.No severe complications following surgery were observed.All patients live in complete remission in a follow up period of 14 months.

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THE BILOBED PECTORALIS MYOCUTANEOUS MAJOR FLAP FOR RECONSTRUCTION OF COMBINED INTRA- AND EXTRAORAL DEFECTS.

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The pectoralis major myocutaneous flap as a standard for reconstruction after oncological resections in the oral cavity was originally described by Ariyan (1979)
Intraoral carcinomas situated around the mandible or in the floor of the mouth eventually invade the perioral soft tissues. Besides the intraoral defect, a full-thickness defect of the facial soft tissues may be created by the resection.
The bilobed pectoralis major myocutaneous flap enables a soft tissue reconstruction of both defects.The small desepithelialised area between both skin islands permits sufficient plication of the flap to enable a correct positioning, without endangering the vascularisation.
This technique was used in 4 oncological cases and in two reconstructions after gunshot blasts causing extensive bone and soft tissue loss. In one case, partial necrosis of the extraorally situated skin island occurred. In all other cases, healing was uneventfull. Oral fistulas did not develop. Apart form the distinct pigmentation, the esthetic results were satisfying.
Without prelevating a second myocutaneous flap or performing time-consuming microsurgical procedures,this modification of the pectoralis major myocutaneous flap provides large amounts of soft tissue based on one vascular pedicle, both for the floor of the mouth and the facial full-thickness defect.

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MANDIBLE RECONSTRUCTION IN RADIATED PATIENTS

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In many patients with a malignant facial or intraoral tumour a resection of the mandible during tumour operation was necessary. Various patients got a pre- or postoperative radiotherapy, all had at least a dose of 50 Gray.
In these cases a reconstruction of the mandible was very difficult because of the irradiated tissue in that area. Different technics were used. The mandible was reconstructed with reconstruction plate only, titan mesh with bone chips, free bone transfer or free microvascular osteomyocutaneous flap.
In cases in which a reconstruction plate was used, the skin or intraoral mucosa was perforated. It was necessary to take it out again or cover it with a flap of non radiated tissue. The same problems were seen in cases with titan mesh, bone chips were mostly disintegrated.
Till today, we transplanted 10 microvascular free osteomyocutaneous flaps. In 2 cases the blood supply decreased. In 1 of these cases whole bone was lost, in the other bone was partly disintegrated. The osteomyocutaneous flaps got dental implants on which later dental prosthesis were fixed, to give patients the masticating function back.
Microvascular osteomyocutaneous flaps seem to be the only reliable transplant for mandible reconstruction in radiated patients. It also gives the patient the best functional result.

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