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REGARDING "MANDIBULAR RECONSTRUCTION WITH A DEEP CIRCUMFLEX ILIAC ARTERY FLAP USING COMPUTER-ASSISTED AND INTRAORAL ANASTOMOSIS TECHNIQUES"

To the Editor:—I read with great interest the article by Zheng et al[1] about reconstruction of the mandible with the deep circumflex iliac artery (DCIA) flap using computer-assisted technique and intraoral anastomosis. The authors point out that the main advantage for intraoral anastomosis is the absence of an extraoral incision or scar. This statement is true; however, some points and limitations about intraoral anastomosis were not reported in the article. Thus, I would like to stress a few important issues.

First, in their case series of 4 patients, most of the mandibular pathology was benign, with 1 low-grade malignancy (low-grade osteosarcoma). They did not stress that only benign pathology permits an intraoral approach for the segmental resection of the mandible. For malignant pathology, an external approach from the neck would be more advisable to obtain adequate surgical margins and perform potential neck dissection and prepare the vessels for the microvascular reconstruction.

Second, the pedicle length for mandibular reconstruction with a DCIA flap will not be a problem because the neck vessels are close to the mandible. Thus, intraoral anastomosis will not be necessary as it is for maxillary reconstruction.

Thus, the approach to resect the mandible and perform the reconstruction through the intraoral approach is advisable only for those with benign mandibular pathology.

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Reference

1. Zheng L, Wu W, Shi Y, Zhang J: Mandibular reconstruction with a deep circumflex iliac artery flap using computer-assisted and intraoral anastomosis techniques. J Oral Maxillofac Surg 77: 2567, 2019

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REPLY

To the Editor:—Thank you for giving us the opportunity to reply to the Letter to the Editor in response to our report "Mandibular Reconstruction With a Deep Circumflex Iliac Artery Flap Using Computer-Assisted and Intraoral Anastomosis Techniques."[1] We appreciate the Letter to the Editor by Dr Dediol for his constructive comments. Our responses to the issues that were raised follow.

First, we agree with Dr Dediol's statement that benign mandibular pathology permits an intraoral approach. Furthermore, the approach to resect and reconstruct the mandible through the intraoral approach is advisable for patients with low-grade malignant mandibular pathology. Also, the intraoral approach without skin scars is preferred for patients with congenital deformities and patients with post-traumatic defects requiring mandibular reconstruction who require more esthetic results.

Second, the pedicle length for mandibular reconstruction with a deep circumflex iliac artery (DCIA) flap is suitable for both intraoral and extraoral anastomosis. We chose the intraoral anastomosis to reconstruct the mandible with a DCIA flap, not only because the intraoral anastomosis technique is especially valuable in select patients who have a high demand for esthetic reconstruction, but also because it can benefit patients predisposed to forming keloids. In addition, the potential risk of stigmatization of young patients is avoided, which could cause severe psychological problems in a pediatric population.[2]

Finally, facial nerve branches could be damaged because of its lateral course in relation to the facial vessels; thus, injury and paralysis of the nerve could be avoided.[3] Therefore, an intraoral anastomosing technique should always be one of the optimal options in the strategy of personalized mandibular reconstruction after segmental mandibulectomy.

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