Case Album

Dr. Amol A. Ghaisas MDS, FHNOS Oral & Maxillofacial Surgeon Head & Neck Oncosurgeon

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About the Surgeon

Dr Amol Ghaisas practices full scope of Maxillofacial surgery with special interest in Head and Neck Oncosurgery.

After completing his post graduation in 2011, he received extensive training in the field of Head and Neck Surgical Oncology. At present he is involved in private practice in dombivali and is attached

to many hospitals.

- FHNOS (FELLOWSHIP IN HEAD AND NECK SURGICAL ONCOLOGY) REGIONAL CANCER CENTRE, GWALIOR.
- MDS IN ORAL AND MAXILLOFACIAL SURGERY (JUNE 2012) FROM BHARTI VIDYAPEETH UNIVERSITY, PUNE.
- BDS (JUNE 2007) BHARTI VIDYAPEETH, PUNE.
- BLS AND ACLS LIFE SUPPORT PROVIDER CERTIFIED BY AMERICAN HEART ASSOCIATION.



DR AMOL A. GHAISAS

- * Fellowship In Head And Neck Surgical Oncology, Regional Cancer Center, Gwalior.
- * Worked as Senior Registrar In Hcg Manavta Cancer Hospital And Research Center, Nashik, Maharashtra For 6 Months
- * Observer in Tata Memorial Hospital, Mumbai in Dept. Of Head And Neck Surgical Oncology.
- * Have Documentation Of Around 300 Cases, Independently Operated Covering A Wide Range Of Maxillofacial And Head Neck Surgery.
- * Five Year Experience of Private Practice as a Maxillofacial Surgeon Based In Thane District. Consultant at various Hospitals
- * Operated Variety Of Maxillofacial Trauma And Pathology At Various Centers.
- * Clinical Assistance For 2 Months In Meenakshi Ammal Cleft And Craniofacial Center (Chennai).
- * Have conducted dental checkup camps in various schools and institutions as a part to create oral cancer awareness.
- * Also invited as a quest speaker at various events.
- * Have Presented papers and posters at various National Conferences.
- * Attended various conferences and workshops.

- Clinic Address -

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About "Yashada Medical Foundation"

The Pain and the course of treatment of oral cancer is associated with mental, physical and social trauma, Also when the cost of the treatments are not possible to bear, patients suffer even more.

In India mortality levels are high due to the delay in reaching a proper diagnosis and delay in starting the treatment.

In the view to help needy patients suffering from oral cancers -'Yashada Medical Foundation" - a registered charitable trust was established in the year 2014. In the same year trust also acquired 80 G certificate which gives Tax exemption to donors.

Trust has collaborated with some surgeons and hospitals which offer treatment including surgery to needy patients at subsidized cost.

Apart from providing oral health care facilities to masses from lower socio economic strata it also conducts oral cancer screening and awareness programmes at various locations regularly.

Trust also runs charitable dental clinic at present where doctors offer full range of dental treatment under one roof.

Trust also urges and encourages help in the form of valuable donations and welcomes volunteering.

We request you to refer the patients suffering from oral cancers and convey the message regarding our work.

With the help of this case album we try to present some of our work, where some needy patients have been operated by Dr Amol Ghasias.

Trust office and Clinic address

Prasad Bld, Ground Floor, Kopar Cross Road, Shastri Nagar, Opposite Shivsena Office, Dombivali (west) 421202.

Phone No- 0251-2489840

Note - Intention of the case album is to portray the surgical experience of Dr Amol Ghaisas. - Main operating surgeon for all the cases in the album is Dr Amol Ghaisas.

- Necessary consent for publishing photos have been taken from patients.

ORAL CANCER CARCINOMA OF ORAL CAVITY

There are about 7,00,000 of cancers patients diagnosed every year in India out of which 3,00,000 cases belong to head and neck region.

Cancer is an end product of unregulated proliferation of cells.

Spectrum of Oral Cancer

90% squamous cell carcinoma

Rest are verrucous, Malignant melanoma and other rare varieties

Definitive Etiology

- Tobacco

- Alcohol
- Dietary Factors
- Poor Oral hygiene, HPV (1%)

Oral cancer can also arise without an associated precancerous lesions

Oral cavity cancers account for 30% of Head and neck Cancers and represent a significant challenge to clinicians. Treatment requires multi disciplinary expertise and is complicated by the complex role that the oral cavity plays in speech, mastication & swallowing.

Early detection and appropriate treatment remains the most effective weapons against cancer.

INOMA OF ORAL CAVITY ORAL CANCER ARCINOMA OF ORAL CAV ORAL CANCER ORAL CANCER

Patient Age/Sex : 58 Years/M, Occupation - Farmer

Chief Complaint: Ulcerative lesion in Oral cavity gradual increase in size.

Habit History : Tobacco and Pan chewer since 40 years.

On Examination:

- E/o Ulcerative lesion (L) cheek 2.5 x 3 cm, skin fixed **Trismus - present**
- Ulcero proliferative lesion involving Buccal Mucosa (L) side and approaching (L) l/o gingivo buccal sulcus.

Lymphadenopathy: Submandibular Nodes-Palpable and Tender

Biopsy Positive for Squamous cell carcinoma

Treatment Given: Composite resection of (L) Buccal Mucosa and segmental resection of mandible + Radical Neck dissection + Reconstruction with Bilobed Pectoralis Major Myocutaneous Flap (PMMC) + Tracheostomy



Preoperative Extra Oral profile view



Intra Oral Pic



Modified criles Incision



Intra Operative Pic showing L) RND



Enblock resection of Buccal Mucosa (L) and segmental resection of Mandible + LN dissection (L)



Immediate post operative view with reconstruction by PMMC (L) (Biloped)



Post Operative 1 month

Histopathologic Diagnosis -

squamous cell Carcinoma All margins were free of Tumour LN : Level I, III showed metastasis, I, IV not involved Perineural Invasion: present Depth of Infiltration : 6 mm

Patient was advised for Adjuvant Radiotherapy.

Patient Age/Sex : 52 Years/M

Chief Complaint-Extra Oral Ulcerative lesion

Habit History : Tobacco & Gutka chewer since 20 years

On Examination:

- E/o Large Ulcerative lesion on (L) cheek 4x5 cm Skin Fixed Trismus present
- I/o Ulcero proliferative lesion on (L) Buccal mucosa approaching (L) Gingivo buccal sulcus

Lymphadenopathy: Upper jugular node palpable and non tender

Biopsy: Positive for squamous cell carcinoma

Treatment Given: Composite Resection (L) BM + (L) Mandibular segmental Resection + (L) RND + (L) Bilobed PMMC Flap + PMMC Flap reconstruction



Extra Oral profile views



Intra Oral Pic



Intra operative View showing (L) RND



Resected Specimen



(L) Bilobed PMMC Flap harvested



Defect in chest to be closed by Primary closure



Flap tunneled into Neck to Cover the defect



(Pectoral Br of Thoracro acromial artery)



(L) PMMC Flap sutured and Extraoral closure



(L) PMMC Flap sutured intraorally

MANAGEMENT OF ORAL SQUAMOUS CELL CARCINOMA OF (L) RETROMOLAR AREA

Patient Age : 42 Years/M, Occupation - Driver

Chief Complaint: Non healing ulcer in Oral Cavity

Habit History: Tobacco chewing since 15 years.

On Examination:

Ulcerative lesion in (L) RMA area approaching 2x2 cm approaching (L) Gingivobuccal sulcus

Lymphadenopathy: Submandibular Node palpable and Tender

Biopsy: Positive for squamous cell carcinoma

Treatment Given: (L) Hemimandibulectomy + (L) MRND II + (L) PMMC Flap reconstruction



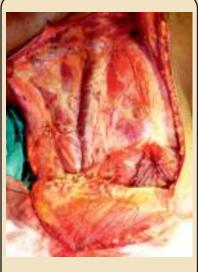
Extra Oral profile views



Intra Oral views



Marking for Incision



MRND II done



Hemimandibulectomy + MRND done



MANAGEMENT OF ORAL SQUAMOUS CELL CARCINOMA OF (L) RETROMOLAR AREA



Marking for PMMC Flap



Vascular pedicle (Pectoral Branch of Thoracoacromial artery)



Intraoral Closure



Skin paddle of (L) PMMC Flap raised



Flap tunnelled into the Detect



ExtraOral Closure

MANAGEMENT OF SQUAMOUS CELL CARCINOMA OF (R) BUCCAL MUCOSA



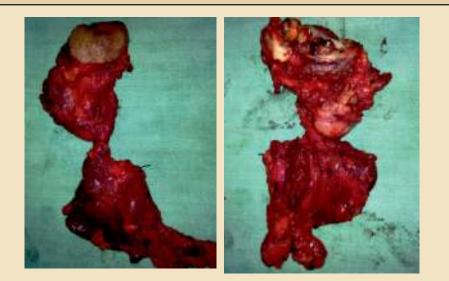
Marking for Incision



Composite resection + (L) RND- Radical Neck Dissection

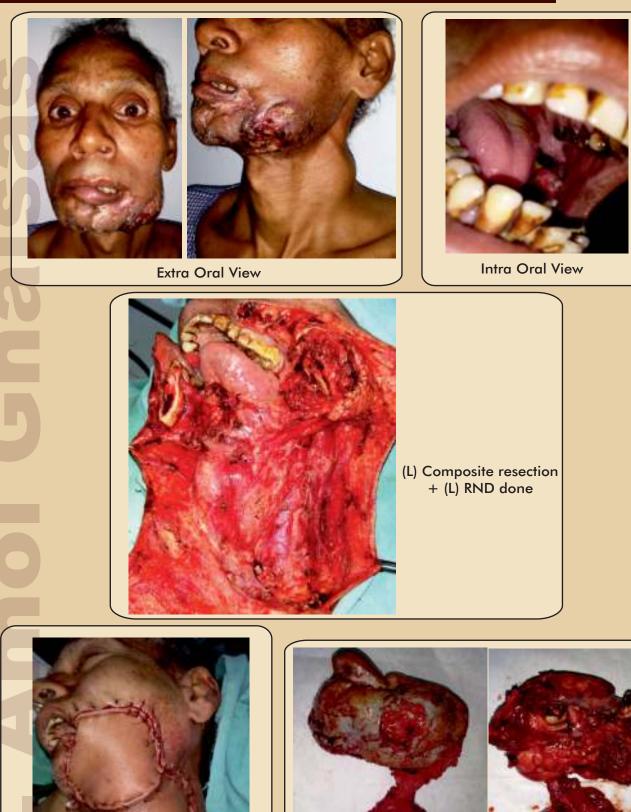


Reconstruction (L) PMMC Flap

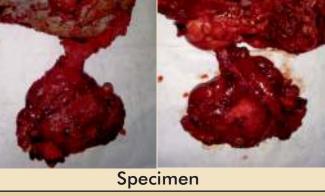


Specimen 8

MANAGEMENT OF CARCINOMA BUCCAL MUCOSA (R)



Reconstruction with bilobed PMMC Flap



Ц

MANAGEMENT OF CARCINOMA OFb(L) LATERAL BORDER OF TONGUE

Age: 32, Sex M

Chief Complaint: Ulcerative lesion over Tongue, Difficulty in Swallowing Habit History: Tobacco and Gutka chewing since 8 years
On Examination:

Ulveroproliferative lesion over (L) lateral border of tongue
4 x 4 cm in size
Floor of mouth : Not involved
Tongue was mobile
Base of tongue: Not involved

Biopsy : Positive for squamous cell carcinoma

Treatment Given: (Lt) Hemiglossectomy + (L) MRND II + Primary Closure



Extra Oral Profile View



Intra Oral View



MRND II preserving spinal accesory Nerve and Internal Jugular vein



Tongue Specimen





Primary Closure Intra Orally



MANAGEMENT OF (RT) CARCINOMA OF LIP

On Examination:

Ulcerative lesion on ® lip involving skin and extending intra orally to GingivoBuccal sulcus

Biopsy : Squamous cell carcinoma



Extra Oral Profile View



Intra Oral View



Marking for Excision and Modified Criles Incision



(R) Wide Excision of Lip with(R) Hemimandibulectomy +(R) Radical Neck Dissection



Reconstruction with Bilobed Pectoralis Major Myocutaneous Flap (Bilobed)



specimen

NECK DISSECTION

Surgery is the oldest form and continues to be the most reliable form of treatment of Malignancy. The management of neck in patients with squamous cell carcinoma of Head & Neck region continues to be most controversial issue in Head & Neck oncology

Cervical Node Metastasis is the single most important prognostic factor in head and Neck squamous Carcinomas

Necks dissection is actually a surgical dissection of the anterior and lateral Neck for purpose of removing tumour and cervical lymph bearing tissues.

Neck dissection requires a good surgical experience and skill as it involves many vital anatomical structures.

TYPES:

Radical Neck Dissection (RND) Modified Radical Neck dissection (MRND) MRND I: - Spinal accessory Nerve preserved MRND II: - Spinal accessory Nerve and internal jugular vein preserved MRND III: - Spinal accessory Nerve, Internal Jugular vein and sternocleidomastoid Muscle preserved

Supra Omohyoid Neck dissection (SOHND)



RND



MRND I



MRND I





AXILLOFACIAL PATHOLOGY

MAXILLOFACIAL PATHOLOGY

OCYST & TUMORS OF ORAL CAVITY

Cyst & Tumors of Head & Neck Regions:

Cyst may be unilocular or Multilocular Sac like lesion enclosed by a capsule.

Cyst may occur any where in the body but head and neck region is the most common site, this is because of the Complex embryology and development of teeth with the presence of varying amounts of residual islands which are potentially capable of being involved in the development of cyst.

Cyst may assume large portions causing much local bone destruction with expansion & disfigurement. Cyst may interfere with normal tooth eruption. Malignant transformation of the cystic lining is also a possibility.

MANAGEMENT OF A CYSTIC LESION IN MAXILLA

Patients Age/Sex : 12 Years/M

Chief Complaint

Swelling over (L) Anterior Maxillary area **On Examination:**

- I/O Mixed Dentition, No Fistulous tract
- Obliteration of Buccal Vestibule
- Compressible Swelling
- Mild Extra Oral Facial Asymmetry
- Nasolabial fold obliterated
- No Cervical Lymphadenopathy



Pre Operative Photograph Oral Intubation done

Pre operative OPG & 3DCT Face with reconstruction



Showing large unilocular radiolucent lesion in (L) Maxillary region with pathological Migration of teeth

Treatment Given:

Enucleation of the cystic lining along with removal of involved tooth. <u>1</u> Migrated and approaching (L) Nasal cavity

Migrated to Floor of Sinus

Migrated close to Floor of orbit



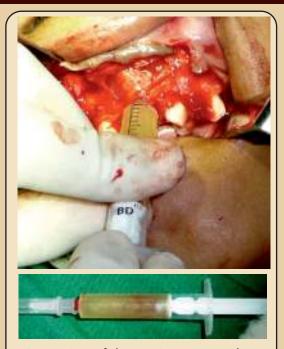
3

Crevicular Incision given



Flap raised exposing thinned out bone

MANAGEMENT OF A CYSTIC LESION IN MAXILLA



Aspiration of the cystic contents done



Cystic lining with involved teeth



Window made in the thinned out bone and cystic lining separated from the bony walls



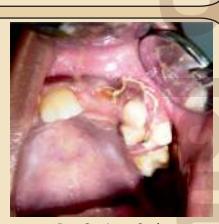


ASE

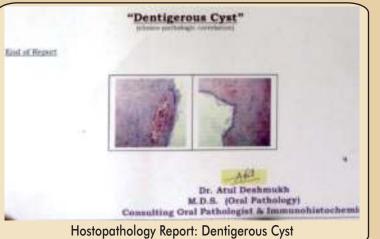
Cystic lining removed meticulously avoiding injury to adjacent structures



Post Op. extraoral



Post Op. Intra Oral





MANAGEMENT OF CYSTIC LESION IN ANTERIOR MAXILLARY REGION B/L

Patient Age/Sex : 10 Years/M

Chief Complaint

Swelling in (L) Maxillary anterior region with Gradual Increase in size. **On Examination:**

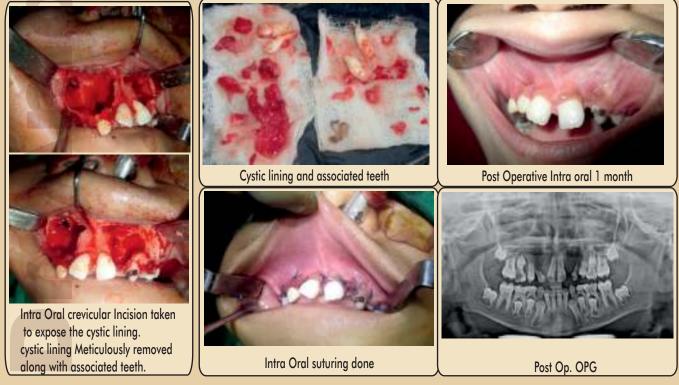
On Examination:

- Mild facial asymmetry
- Obliteration of Buccal vestibule
- Soft Compressible Swelling intra orally



- Showing radiolucent lesion in anterior Maxillary region bilaterally associated with un erupted permanent teeth
- Posterior Displacement of Maxillary Sinus
- pathological migration of un erupted teeth.

Treatment Given: Enucleation of cystic lining along with removal of associated teeth.



Histopathology Finding : Dentigerous Cyst

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MANAGEMENT OF CYSTIC LESION IN MANDIBLE

Patient Age/Sex : 30 Years/F

Chief Complaint: Pain on left side of lower jaw.

On Examination:

No significant finding intra orally, So a OPG was advised which showed a large cystic lesion on left side of mandible associated with (L) impacted 3rd Molar teeth.



Preoperative Photograph



Preoperative OPG Large cystic lesion in (L) side of Mandible associated with Left Impacted 3rd Molar extending to sigmoid Notch and showing Significant resorption of bone



Intra oral preoperative photograph

Treatment : Enucleation of the cyst Intra orally



Intra oral Incision taken to expose the Bone



Window created in bone and cystic lining removed, care taken to avoid injury to inferior alveolar nerve



Bone Cavity irrigated and Carnoys solution applied to bony wall (Chemical cauterisation)



Cavity packed with iodine Gauze and Mucosa sutured

MANAGEMENT OF CYSTIC LESION IN MANDIBLE



Removal of associated teeth



Removed cystic lining



Post operative Intra Oral Pic showing healing

Morbid Anatomy

Cyntic, sac like soft tissue specimen is received from mandibular left third molar region.

Histopathology Findings: (Hematosylese & Essin stained sections)

The sections show cystic cavity lined by odontogenic epithelium. Basal cells are tall columnar with hyperchromatic nuclei, placed away from basement membrane. Bud like differentiation of epithelial lining is noted. Superficial areas show stellate reticulum like cells. At places, plexiform growth of odontogenic epithelium within cystic cavity is noted.

Impression:

"Unicystic Ameloblastoma -Intraluminal Growth"

Rol of Report

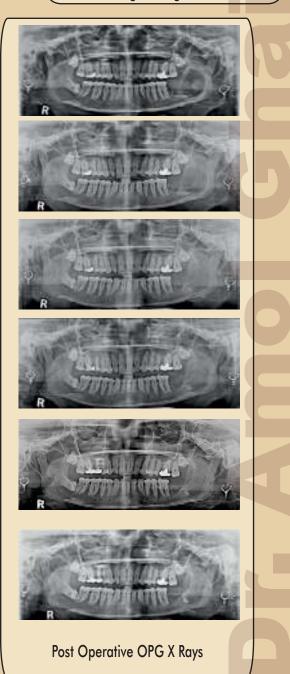


Histopathology Finding "Unicystic Ameloblastoma - Intra luminal Growth"

Patient was kept on regular follow up for 4 years and subsequently monitored by taking regular OPG



Remarkable bone fill and healing



MANAGEMENT OF A INTRABONY LESION IN ANTERIOR MANDIBLE



Patient Age/Sex : 16 Years/F Chief Complaint:

Patient had come for a routine dental checkup for which a OPG X-RAY was advised accidentally the OPG showed a large multilocular lesion in anterior mandible.

On Examination:

No Obliteration of Buccal Vestibule Patient was asymptomatic



Preoperative Photograph



Pre operative OPG: showed a Multi locular radiolucent lesion extending till lower border of mandible and involving all teeth from (Rt) premolar to (Lt) Premolar



done for all involved teeth before sugrery



Intra Oral Crevicular Incision taken

Considering the age of the patient Treatment plan decided was enucleation of the Intra bony lesion along with application of Carnoy's Solution to bony walls.



Parent was kept under Observation post operative and monitored by regular follow ups and OPG X-Ray



MANAGEMENT OF AMELOBLASTOMA IN MANDIBLE

Patient Age/Sex : 52 Years/M

Chief Complaint Intra Oral Swelling associated with Mild pain. Patient also gave H/O Enucleation done 1 year back at some other centre. On Examination: Hard swelling on palpation No Fistulous discharge Obliteration of buccal vestibule





3 DCT scan with reconstruction showing erosion of bone cortex buccal and lingually also approaching lower border of mandible



Preoperative Intra Oral Pic

Treatment Given: Segmental resection of Mandible involving the lesion with safe bony margin and reconstruction with Titanium locking reconstruction plate.



Arch Bar placed on (Rt) side (Opp side) for IMF and to maintain occlusion on (Rt) side.



Intra vestibular Incision taken to expose the lesion Anteriorly



Template was used to adapt the reconstruction plate



Submandibular Incision taken to exposed the posterior Mandibular bone preserving marginal Mandibular nerve, facial artery and vein identified and ligated

MANAGEMENT OF AMELOBLASTOMA IN MANDIBLE



Anterior & posterior bony cuts made and segmental resection done with safe margins



Resected Mandibular Segment



Adapted Reconstruction Plate fixed with Screws



Extraoral Closure





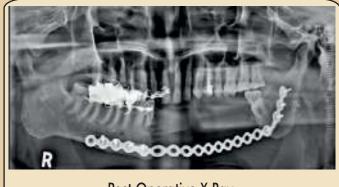
Guiding elastics used on arch Bar to guide the Mandible in occlusion on ® side



MANAGEMENT OF AMELOBLASTOMA IN MANDIBLE



Post Operative Intra Oral Healing



Post Operative X Ray Showing Titanium reconstruction plate

MANAGEMENT OF AMELOBLASTOMA IN MANDIBLE (R)

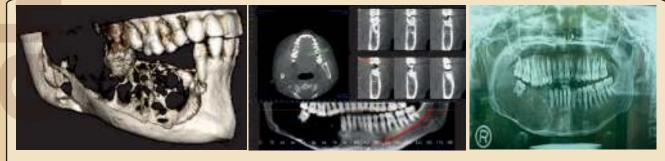
Patient Age/Sex :38 Years/F **Chief Complaint** Patient Complained of Swelling Intra orally **On Examination:** Mild Extra Oral swelling Obliteration of Buccal vestibule Mobile teeth.



Preoperative Profile views



Intra Oral Pre operative Pic showing obliteration of Buccal vestibule



CBCT of Mandible

OPG

Showing large multilocular Radiolucent lesion involving right halt of Mandible Erosion of Buccal and lingual cortical plates.

Treatment Given:

Segmental Resection of Mandible (R) involving lesion and reconstruction with Free Fibular Vascular graft by a Micro vascular surgeon (Dr Nikhil Agarkhedkar).



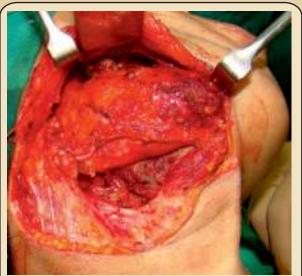
X Ray of Rt & Lt Leg



Markign for (Rt) submandibular Incision

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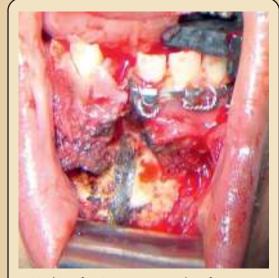
MANAGEMENT OF AMELOBLASTOMA IN MANDIBLE (R)



Supra platysmal flap raised to expose the lesion Facial artery and vein identified and prepared



Resected Mandibular Segment



Marking for Anterior cut with safe margin



Marking for free Fibular Graft on Lt Leg



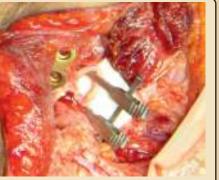
Free fibular Graft raised and adapted to pre adapted reconstruction plate keeping the peroneal vessels attached



Adapted Free Fibular Vascular graft on Reconstruction Plate with Peroneal artery and vein prepared

MANAGEMENT OF AMELOBLASTOMA IN MANDIBLE (R)





Micro vascular anastomosis of Peroneal artery with Facial artery and peroneal vein with facial vein



Fixed Free Fibular Graft with anastomosis with good vessel fill



Intra Oral Suturing



Tracheostomy





Post Operative Profile View



Post Operative Intra Oral Pic with healthy skin paddle



Post Op X Ray showing fixedDouble Barrel Free Fibular Graft

Morbid Anatomy:

- Resected mandibular specimen received.
- A: Tumor lining
- B: Lymph Node
- C: Margins [Superior/Inferior/Anterior/Posterior]

Histopathology Findings: (Hematoxylene & Bosin stained sections)

A: Tumor Lining:

Ameloblastomatous transformation of epithelium is evident. Epithelium is following Vicker's & Gorlin's criteria for smelblastoma.

B: Lymph Node:

No evidence of infiltration of tumor tissue within lymph node.

C: Margins Superior/Inferior/Anterior/Posterior]:

All the margins are clear of tumor tissue infiltration.

Impression:

A: Tumor lining: "Ameloblastoma"

B: Lymph Node: "CLEAR"

C: Margins [Superior/Inferior/Anterior/Posterior]: "CLEAR"

Histopathology Finding "Ameloblastoma"

MANAGEMENT OF LARGE CYSTIC LESIONIN (L) MANDIBLE

Patient Age/Sex : 56 Years/M

Chief Complaint Mild extra oral swelling **On Examination:** Patient was asymptomatic



Preoperative Profile views

Area of Interest - 38 .



Pre operative OPG showing large cystic lesion in left side of the mandible with pathological migration of lower left third molar

38 - shows displaced to te ramus area in almost horizontal direction ,with smooth, round, clear radiolucency around the crown of the tooth attached to the CEJ suggestive of cystic lesion and causing slight root resorption of distal root of 37.

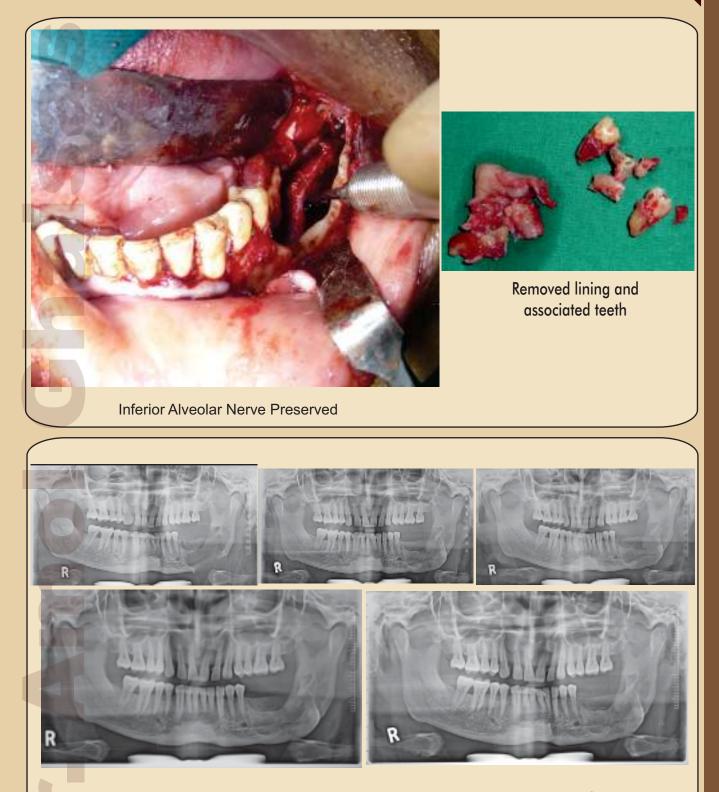
D/D- Dentigerous cyst/Odontogenic Keratosis/ameloblatoma??

Radiological dignosis



Intra oral incision taken to expose bone. Bony window created and cyst lining removed

MANAGEMENT OF LARGE CYSTIC LESION IN LEFT MANDIBLE



Post operative OPG : patient kept under observation and regular follow up OPGs taken showed good bone fill and bone remodelling post operatively



Patient Age/Sex : 4 Years /M

Chief Complaint:

Patient complained of swelling in lower right posterior region of the mandible



Preoperative



Intra orally- Mild obliteration of the buccal vestiule



Intra oral crevicular incision taken to expose the bone and bony window created to remove the cystic lining along with associated tooth .

Infra alveolar Neuro vascular bundle meticulously separated from cystic lining and preserved





Preoperative OPG and CBCT showing radiolucent region in right mandible associated with unerupted teeth



Histopathologic finding : Dentigerous Cyst 28

PREMALIGNANT CONDITION

PREMALIGNANT CONDITION

Oral Submucous Fibrosis

Oral Submucous Fibrosis (OSMF) US Fibrosis

Oral Sub mucous Fibrosis results in stiffness of oral mucosa and leads to progressive decrease in mouth opening.

Oral submocous fibrosis comes with a high risk of malignant transformation and hence requires sufficient measure to be cured.

It is of special concern to the oral and maxillofacial surgeons of the subcontinent due to wide spread use of causative agents and racial predisposition of this condition.

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PREMALIGNANT CONDITION

Submucous Fibre

MANAGEMENT OF ORAL SUBMUCOUS FIBROSIS

Age/Sex : 52 /M , Occupation-Driver **Chief Complaint:** Restricted Mouth opening Burning sensation **Habit History:** Chronic Gutka Chewer **On Examination:** E/O : Maximum Inter-incisal opening : 8-10 mm

I/O : Vertical Fibrous Bands in Buccal Mucosa ,Blanched Mucosa

Treatment Given: Intubation with Fiberoptic Bronchoscopy Bilateral Excision of Fibrous Bands , Bilateral Nasolabial Flap Reconstruction

Excision of Fibrous Band done Intra Orally using mouth gag mouth opening achieved
was 40mm Intra operatively



Inferiorly based Nasolabial Flap raised Bilaterally



Transbuccal tunnel made and Flap transposed intra orally in a tension free manner



Flap sutured intra orally in the detect created by excision of fibrous bands





Post operative pic Showing the vitality of the flap



Post operatively increase in mouth opening maintained by aggressive physiotherapy

THOGNATHIC SURGERY ORTHOGNATH SURGERY

ORTHOGNATHIC SURGERY

Dento-facial Deformities affect 20% of the population. The patient often seeks treatment to correct the abnormality due to Variety of reasons.

The success of Orthognathic Surgery depends on recognizing patient concerns, patient expectations, evaluation and assessment of problem and most importantly planning the treatment.

The process of treatment planning should be done in a Systematic manner. It starts from selecting the patient to surgery, understanding and co-operation from oral and maxillofacial surgeon, Orthodontists, general dentists, patient as well patient parents.

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MANAGEMENT OF DENTOFACIAL DEFORMITY BY ORTHOGNATHIC SURGERY

Patient Age/Sex : 25 Years/M

Client Complaints :

Complaint of frowardly placed upper front teeth and abnormal chin



Pre Operative Photo

General Examination: Physique : Ectomorphic Profile : Convex Lip Line : Gummy Lips : Incompetent

Growth Status: Post Pubertal Mandible : Retrusive Lower Lip : Trapped Chin : Recessive



Preoperative Occlusion

Maxillary and Mandibular Incisors were Proclined

Over Jet: 11 mm Over bite : 6 mm



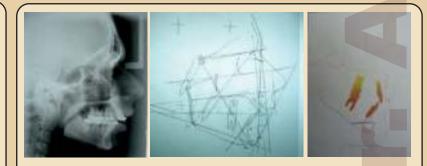
Preoperative Xray Lateral Cephalogram

Phases of Treatment

- Presurgical Orthodontics
- Surgical Phase
 Post Surgical Orthodontics
- Post Surgical Orthodon



Patient received Pre surgical Orthodontics for Correction of Dental Deformity Levelling and alignment of (U) & (L) arches



Cephalometric analysis and Tracings were done and surgical plan was formulated

MANAGEMENT OF DENTOFACIAL DEFORMITY BY ORTHOGNATHIC SURGERY

Treatment Plan:

BSSO For Mandibular Advancement - 6 mm Sliding Genioplasty - 6 mm No Surgical Intervention for Maxilla







Intra Oral Incision taken B/L Osteotomy Cuts defined with an Osteotome Mandible is Split Intra Operative Splint was placed in (U) arch, Mandible advanced and lower teeth placed in the Splint







Chin bone exposed Via Intra Oral Incision, Bone Cuts defined Sliding Genioplasty done and Fixation done with Titanium Miniplates and Screws





Post Operative Profile Views



Post Operative Occlusion



Post Operative X Rays Showing Fixation with Titanium Mini Plates and Screws

MANAGEMENT OF DENTOFACIAL DEFORMITY BY ORTHOGNATHIC SURGERY





Before



5

AS

Π





After





MAXILLOFACIAL TRAUMARAUM RAUMA LOFACIAL JMA LOFACIAL

MANAGEMENT OF SEVERE LACERATED WOUND OVER FACE

Soft tissue injuries to the facial structures are one of the most common situations encountered in trauma patients. It may vary from simple abrasion to deep and severe injury involving important anatomical structures.

Wound irrigation and debridement play a key role to avoid foreign body reaction and infection in these cases.

A 25 year old male was reported to casualty with alleged history of RTA (Road traffic Accident)

No H/O loss of consciousness, ENT Bleeding or Vomiting, Diplopia

Head injury was ruled out following initial assessment & examination and 3DCT Face was done.



Extensive cut and lacerated wound (18cm) L side from intra orbital margin to submental area crossing along nasolabial fold causing complete split of upper and lower lip.

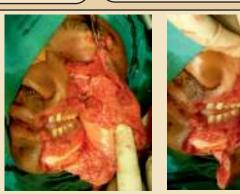


Axial and coronal CT scan with 3D reconstruction showing displaced Zygomatico-oribtal complex fracture on left side



Wound irrigation done using normal saline and repeated debridement with soft brush, gauze and atraumatic forceps

Multiple facture sites reduced and fixed with transosseous wires

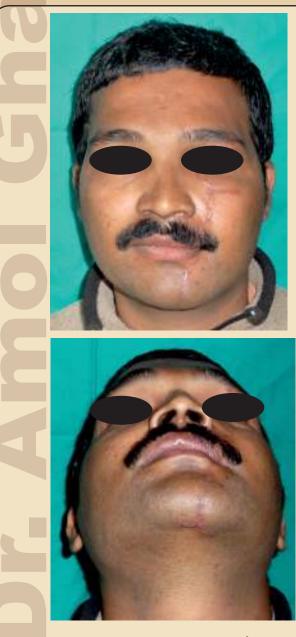








Closure commenced from inner to outer surface, special care taken to align orbicularis oris muscle, Nasolarimal duct opening protected and eyelid sutured with ethilon.



Post operative 3 months



Post operative occlusion



Post operative X Ray

MANAGEMENT OF PAN FACIAL TRAUMA

PAN Facial Trauma is one of the most challenging variety in maxillofacial trauma to obtain good results post-operatively.

Reestablishment of Facial height, width and projection along with sequencing of fracture sites are the important aspects to avoid Facial deformities post operatively.

Patient age 35 years, a case of RTA (Road Traffic accident) reported to casualty. No History of ENT Bleed, vomiting or loss of consciousness, Diplopia.

On Examination: Superficial abrasions over face were seen.

Intra orally complete maxilla was mobile with Malocclusion showing anterior open bite. After Initial Examination, head injury component was ruled out and a 3DCT Face was done which showed a lefort 3 facture (B/L) with nasomaxillary disjunction along with bilaterally displaced condylar facture.

Treatment Plan:

- Submental Intubation to establish occlusion and to avoid injury associated with Nasal intubation in such cases.
- Archbar wiring in upper and lower Dental Arch following Intermaxillary Fixation (IMF) to establish occlusion.
- ORIF (Open reduction and Internal Fixation using titanium Mini plates & Screws.



Preoperative view of facial profile showing super facial abrasions over face and increase in bizygomatic width.





3DCT face showing Multiple fracture sites Lefort 3 fracture B/L NasoMaxillary Disjunction Lt condyle fracture

MANAGEMENT OF PAN FACIAL TRAUMA





Submental Intubation to establish occlusion



Transparotid approach to open Right condylar fracture



Marking for Retromandibular Incision to approach Right Mandibular Condyle Fracture



Right Condylar Fracture Reduced and Fixed with Titanium Miniplates and Screws.



(L) Maxillary Bone Fracture opened, reduced and fixed with Titanium Miniplates and screws.



Post Op. Occusion



Bilateral Frontozygomatic arch Fracture opened, reduced and Fixed with titanium Miniplates & Screws along with (L) Intraorbital rim fracture



Post OP X Rays showing open Reduction & Internal Fixation of Multiple Facial Fracture sites using Titanium Miniplates & Screws.

Post operative 6 months Photograph with Minimal Scar Visible



MANAGEMENT OF RIGHT ZYGOMATICO-ORBITO COMPLEX FRACTURE

Patient Age/Sex : 36/M

Mode of Injury : RTA (Road Traffic Accident)

No History of Loss of consciousness, Epistaxis or vomiting after initial assessment Head Injury component was ruled out.

On Examination: Swelling Right side of face. Difficulty in opening mouth. Loss of zygomatic projection on Right side of face.

Treatment Plan: Elevation of the posteriorly displaced zygomatic complex on right side of face and ORIF open reduction and Internal Fixation of fracture sites using Titanium Miniplates & screws.



Preoperative view



ORIF Open reduction & Internal Fixation of Right Intraorbital Rim fracture with Titanium Miniplates & Screws



Intra oral degloving Incision taken to expose, elevate and reduce zygomatico-maxillary buttress fracture



3DCT face with reconstruction showing ® Zygomatico Orbital complex fracture with posterior displacement



Lateral orbital Incision to expose and reduce (Rt) Fraonto-zygomatic arch fracture



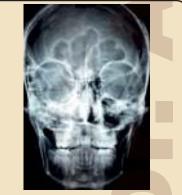
Fixation of Zygomatico-maxillary buttress fracture with Titanium Miniplates & screws



Intra orbital Incision taken to expose and reduce Right Infra orbital Rim Fracture



Fixation of (R) Fronto zygomatic arch fracture using Titanum Miniplates & screws



PA skull X Ray shows ORIF with Titanium plates and Screws at Fracture sites

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MANAGEMENT OF RIGHT ZYGOMATIC COMPLEX FRACTURE

Patient Age/Sex : 28/M Years

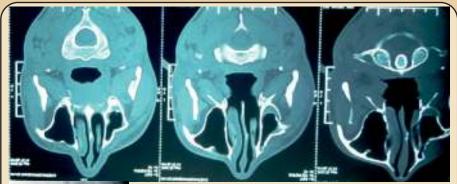
Mode of Injury : Direct blow Over (Rt) Molar Eminence during interpersonal violence.



Preoperative photograph showing loss of Malar eminence on Rt side



Intra orbital Incision was taken to expose and reduced ® Intra orbital Rim Intra Orbital neuro vascular bundle was carefully preserved





-3DCT Face with reconstruction showing Right zygomatic bone fracture -Inwardly displaced fracture of Intra Orbital Rim on Right side -Fracture of Anterior Maxillary wall of Sinus on Right side.



® Intraorbital Rim fracture Fixed with Titanium Miniplates & Screws



Intra oral degloving incision taken (R) Anterior wall of Maxillary sinus elevated and (R) Zygomatic- Maxillary buttress fixed with Titanium Miniplates and screws.



Post Operative X Ray showing Two point Fixation with Titanium Miniplates & Screws on (R) side



Postoperative profile view showing Inconspicuous Intraorbital Scar

MANAGEMENT OF RIGHT ZYGOMATICO COMPLEX AND RIGHT MANDIBULAR PARASYMPHYSIS FRACTURE

Patient Age : 40 years

Mode of Injury: Road Traffic Accident. No History of Loss of consciousness, Epistaxis vomiting. Head Injury Component was ruled out Diplopia / Enapthalmos not present. **Treatment Plan:**

Open reduction & Internal fixation of all fracture sites with Titanium Miniplates and screws.

- 3 points Fixation of (RT) Zygomatic complex fracture.
- Upper and lower border plating for Mandibular Parasymphysis fracture (R)



Preoperative Profile View Swelling Over Right side of Face Subconjunctival Hemorrhage & Ecchymosis Over RT eye.



Preoperative occlusion Displaced Dentoalveolar segment with Anterior open bite



CT Scan showing displaced Mandibular (R) dentoalveolar segment



CT Scan showing inward displacement of Zygomatic bone (R)



Upper and lower arch bar placed occlusion achieved and Maxillo-mandibular Wiring done (IMF)



Intra Oral degloving incision taken Right Mandibular parasymphysis fracture exposed and reduced



Fixation of Mandibular Parasymphysis Fractures done with Titanium Miniplates & Screws preserving Mental nerve

MANAGEMENT OF RIGHT ZYGOMATICO COMPLEX AND RIGHT MANDIBULAR PARASYMPHYSIS FRACTURE



Degloving incision taken to expose Right zyogomatic Maxillary Buttress Fracture Ant wall of Maxillary Sinus elevated



Fixation of Right Zygomatico-Maxillary buttress Fracture with Titanium Miniplates and Screws



Intra Oral Closure



Marking for (R) Intraorbital Incision



Intraorbital Fracture Site Exposed and Reduced.



Fixation of (R) Intra Orbital Fracture with Titanium Minipates and Screws



® Lateral Brow incision taken



Reduction & Fixation of (R) lateral Fronto Zygomatic arch with Titanium Miniplates & Screws



Closure of Intraorbital and Lateral Brow Incision



Post Operative Photograph Minimal Scar Visible

MANAGEMENT OF RIGHT ZYGOMATICO COMPLEX AND RIGHT MANDIBULAR PARASYMPHYSIS FRACTURE



Post Operative Occlusion



Post Op X Ray Fixation with Titanium Miniplates and Screws at Multiple Fracture Sites

MANAGEMENT OF LEFT FRONTO-ZYGOMATIC COMPLEX FRACTURE

Patient Age : 28 years/M **Mode of Injury:** RTA (Road Traffic Accident) No History of Loss of consciousness, Vomiting, ENT Bleed Head injury Component was ruled out No Diplopia / Enopthalmos Not present. **Treatment Plan:** 3 point Fixation of (Lt) Fronto Zygomatic complex fracture using titanium Mini plates & screws.



MANAGEMENT OF (LT) MANDIBULAR CONDYLE FRACTURE AND (RT) PARASYMPHYSIS FRACTURE

Patient Age/Sex : 26 years/M

Mode of Injury: RTA (Road Traffic Accident) No History of loss of consciousness, vomiting, ENT Bleed

On Examination:

- Superficial abrasions over Right Side of Face
- Swelling Over Face
- Intra orally occlusion was Deranged
- • Difficulty in opening the mouth and associated with pain.

Treatment Plan: IMF followed by ORIF (Open reduction and internal fixation) or (RT) Parasymphysis Fracture and (Lt) Candylar Fracture



Preoperative Photo



3DCT Face with reconstruction showing Displaced (Rt) Para symphysis fracture and minimally displaced (L) condylar fracture



Upper and Lower arch Bar Placed



Inter Maxillary Fixation done



Intra Oval vestibular Incision take to expose (Rt) parasymphysis Fracture taking care to avoid injury to Mental Nerve

MANAGEMENT OF (LT) MANDIBULAR CONDYLE FRACTURE AND (RT) PARASYMPHYSIS FRACTURE





Fracture Segments reduced and fixed with Titanium Miniplates and Screw at Upper and Lower border



Marking for Retromandibular Incision to approach (Lt) Condylar Fracture



Fracture Site exposed via Transparotid approach avoiding injury to Marginal Mandibular Branch of Facial nerves



Condylar Fracture segments reduced and Fixed with triangular Titanium Delta plate and screws



Post operative X Ray showing fixation with titanium plates

MANAGEMENT OF (RT) DISPLACED MANDIBULAR CONDYLAR FRACTURE

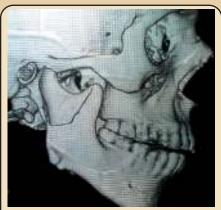
Patient Age/Sex :42 Years/M

Mode of Injury : Direct Blow Over (Rt) Condylar area No History of loss of consciousness, vomiting, ENT Bleed

On Examination:

Swelling over (Rt) Side of face, pain associated with opening of mouth.

Treatment Plan: IMF followed by ORIF of condylar fracture segment using Titanium Miniplates and screws.



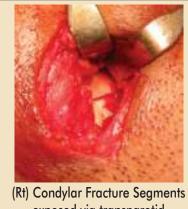
3DCT Face showing laterally displaced (Rt) Condylar Fracture



Marking for Retromandibular Incision to approach (RT) Condylar Fracture



Intra Oral vestibular Incision taken to expose (Rt) parasymphysis fracture taking care to avoid injury to Mental Nerve



t) Condylar Fracture Segment exposed via transparotid approach



(Rt) Condylar Segments reduced and fixed with Titanium Miniplates and screws



Post Op X Ray showing Fixation of Rt Condylar Fracture using Titanium Miniplates & screws

MANAGEMENT OF (RT) PARASYMPHYSIS AND (LT) MANDIBULAR ANGLE FRACTURE

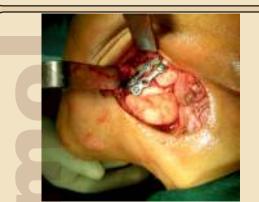
Patient Age/Sex : 18 Years/M Mode of Injury : Sport Injury No History of loss of consciousness, vomiting, ENT Bleed On Examination: Difficulty in opening the mouth. Deranged Occlusion Treatment Plan : IMF followed by open reduction and internal fixation of (RT) parasymphysis fracture and (LT) Angle fracture using Titanium Miniplates and screws.



3DCT Scan of face showing (Rt) Parasymphysis fracture and laterally displaced Mandibular angle fracture



Marking For (Lt) submandibular Incision to expose (Lt)Angle fracture



(Lt) Mandibular Angle fracture exposed Reduced and fixed via submandibular incision with Titanium Miniplates and screws.



Intra oral degloving vestibular Incision taken to exposed (Lt) Parasymphysis fracture taking care to avoid injury to Mental Nerve

(Lt) Parasymphysis Fracture segments reduced and fixed with Titanium Miniplates and screws.



Subcuticular closure of (Lt) side



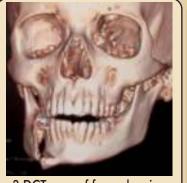
Post operative X Ray showing Fixation of fracture side using titanium miniplates and screws

MANAGEMENT OF RT PARASYMPHYSIS FRACTURE

Patient Age/Sex : 17 Years/M **Mode of Injury :** History of Fall No History of loss of consciousness, vomiting, ENT Bleed **On Examination:** Swelling Over (Rt) Lower Jaw Difficulty in Opening Mouth Deranged Occlusion **Treatment Plan :** IMF followed by ORIF of (Rt) Parasymphysis fracture with titanium plates and screws.



Preoperative Pic



3 DCT scan of face showing (RT) Parasymphysis fracture



Degloving Vestibular Incision taken to expose (RT) Parasymphysis fracture care taken to avoid Injury to Mental Nerve



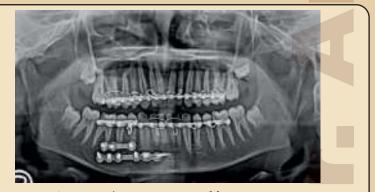
Fracture segment exposed, reduced and fixed with Titanium Miniplates and Screws



Collagen sheet cut to be kept on Titanium plate



collagen sheet creates a barrier between nerve and plates to avoid tingling sensation post operatively



Post Op X Ray showing Fixation of fracture segment with Titanium Plates and screws

MANAGEMENT OF BILATERAL MANDIBULARPARASYMPHYSIS FRACTURE

Patient Age/Sex : 18 Years/M

Mode of Injury : Road Traffic Accident No History of loss of consciousness, vomiting, ENT Bleed

On Examination:

Difficulty in operating the mouth Mobile Anterior Segment Deranged occlusion

Treatment Plan :

IMF in occlusion followed by ORIF of B/L Parasymphysis fracture with Titanium Miniplates and screws.



3DCT scan of face showing Bilateral Para symphysis fracture with Inward Pull of Symphysis Segment



Overlapping of Fractured segments over each other



Upper and Lower arch Bar placed after achieving satisfying occlusion, IMF done





Intra Oral degloving Incision taken B/L to Expose, Reduce and fix Fracture segments with titanium miniplates and screws,IMF released.



Post Operative Photograph



Post Operative Occulusion

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Post operative X Ray showing fixation of thefracture segment with Titanium plates and screws.

MANAGEMENT OF LT PARASYMPHYSIS FRACTURE



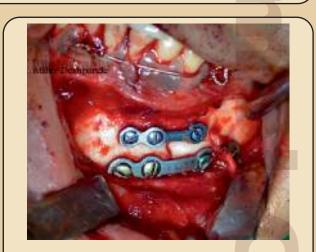
Preoperative Pic Fracture segment immobilised with a bridal wire



Eyelets place in upper and lower arch IMF done after achieving occlusion



Intra Oral Degloving Vestibular Incision taken to exposed fracture line Case taken to avoid Injury to Mental Nerve Mental Nerve Carefully dissected



Fracture segments reduced and fixed with titanium miniplates and screws



Post Operative Occlusion

MANAGEMENT OF LEFT MANDIBULAR ANGLE FRACTURE

Patient Age/Sex : 21 Years/F

Mode of Injury: History of Fall

On Examination: Mild Swelling over Lt Angle Region Difficulty in opening the mouth

Treatment Plan: ORIF of (LT) Angle Fracture Intra Orally with Titanium Plates and Screws.





Preoperative OPG X Ray showing Fracture line passing through 3rd molar teeth



Fracture line exposed via Intra Oral Incision



Fracture Segments reduced and fixed with Titanium Miniplates and screws



Post Op. X Ray showing Fixation with Titanium Plates and screws



Post Operative Occlusion

MINOR ORAL SURGICAL PROCEDURES MINOR ORAL SURGICAL PROCEDU MINOR ORAL GICAL PROCEDURES

MINOR ORAL SURGICAL PROCEDURES

URGICAL PROCEDURES MINOR ORAL SURGICAL PROCEDURES MINOR ORAL SURGICAL PROCEDURES MINOR ORAL

IRGICAL PROCED

SURGICAL REMOVAL OF HORIZONTALLY IMPACTED 3RD MOLAR



Armamentarium



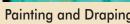
X Ray showing horizontally Impacted (Rt) 3rd Molar



(Rt) 3rd Molar Intra Oral Pic

Crown portion sectioned & removed







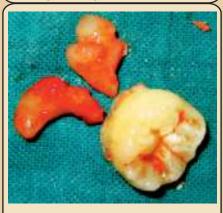
Roots sectioned and removed



Intraoral Closure done



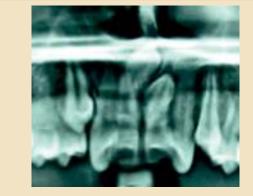
Incision taken to expose bone and bone guttering done around tooth



Extracted 3rd Molar

55

SURGICAL REMOVAL OF SUPERNUMERARY TEETH IN MAXILLARY ANTERIOR REGION



X Ray showing impacted supernumerary teeth



Intra oral incision taken to expose bone Impacted teeth identified and removed



Removed teeth

Ghaisas

REMOVAL OF WART OVER NOSE



Patient complained of Wart over Nose, wanted to get it removed for aesthetic reasons Very slow gradual increase in size over years



Incision taken and removed from base



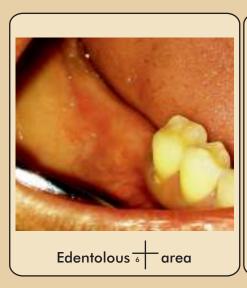
Specimen



Post operative provile view

DENTAL IMPLANT







Dental implant inserted and Abutment placed after 2 months post osteo-integration of Implant surface and bone



Prosthesis (crown) placed over implant

ORTHODONTIC ZYGOMATIC IMPLANTS



Preoperative view on going orthodontic treatment



Anteior openbite need for buccalization and intrusion of posterior teeth





Zygomatic implants placed over zyomatic buttress to provide anchorage for orthodontic forces

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