

Remodeling of Neocondyle

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Abstract

Temporomandibular joint (TMJ) ankylosis in children is one of the most complex and challenging problems managed by oral and maxillofacial surgeons. TMJ ankylosis in growing children often leads to facial deformity, difficulty in chewing and swallowing, severe malocclusion, poor oral hygiene, multiple decayed teeth, and impairment of speech. A good functional and esthetic outcome can be achieved after reconstruction with the autogenous grafts. Here, we present a case of a 9-year-old patient treated with condylectomy and ipsilateral coronoidectomy, followed by reconstruction with costochondral graft with 5 years of follow-up. During this period, the reconstructed graft remodeled into a neocondyle and also regrowth of the coronoid process. The mouth opening and facial symmetry were acceptable.

Keywords: Costochondral graft, neocondyle, temporomandibular joint ankylosis

INTRODUCTION

The term ankylosis is derived from the Greek word meaning “stiffening of a joint.” Ankylosis may be defined as a fibrous or bony union of the condyle of the mandible and glenoid fossa of the temporal bone.^[1] Temporomandibular joint (TMJ) ankylosis in children can lead to devastating effects such as facial deformity, difficulty in chewing and swallowing, severe malocclusion, poor oral hygiene, multiple decayed teeth and impairment of speech, and acute compromise of airway.^[2-5] Various autogenous bone grafts such as costochondral graft (CCG), metatarsal heads, fibula, sternoclavicular joints, clavicle, and iliac crest are being used for the reconstruction of condyle.^[4,5,6] Among these, CCG is the most commonly used, first described by Harold Gilles in 1920, and was popularized by Poswillo.^[2,6] However, the use of CCG has gained popularity because of its biologic and anatomic similarity, ease in obtaining and adapting the graft and its regenerative growth potential, and low morbidity of the donor site.^[1,5,7] Reconstruction with CCG in children provides a growth potential, and it is hoped that it maintains the mandibular symmetry throughout the growth period.

However, excessive and unpredictable growth of the CCG on the grafted site leading to facial asymmetry, progressive dental midline shift, occlusal change, chin deviation, and enlargement of the CCG has been reported in many literature.^[8,9] This article presents a case report of a patient who underwent CCG reconstruction of condyle after resection of ankylotic mass

which remodeled into a neocondyle and also the regrowth of coronoid process with 5 years of follow-up.

CASE REPORT

A 9-year-old male patient reported with the chief complaint of inability to open the mouth and difficulty in chewing for 1 year. His parents gave a history of trauma to the chin 2 years back and noticed progressive limitation of mouth opening. On clinical examination, gross asymmetry was noted with mild deviation of the mouth toward the left side and fullness of the left side and flattening of the right side of the jaw. Interincisal opening of 10 mm was observed [Figure 1]. On local examination, a bony mass was palpable on the left preauricular region. Left TMJ was nonauscultatory. Provisional diagnosis of left TMJ ankylosis was made. Orthopantomogram and computed tomography scan of the TMJ revealed the presence of bony ankylotic mass in the left TMJ region showing displaced condyle fused medially to the ramus [Figures 2 and 3]. Surgical resection of the bony ankylotic mass and ipsilateral coronoidectomy was performed through Alkayat-Bramley incision to improve the mouth opening;

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Figure 1: Preoperative photograph showing limited mouth opening

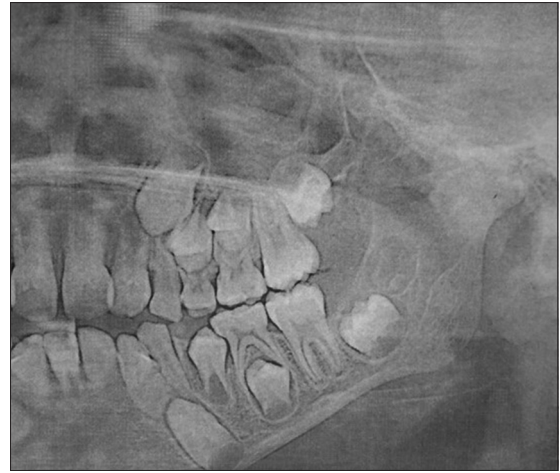


Figure 2: Preoperative orthopantomogram showing the ankylotic condylar mass



Figure 3: Preoperative coronal computed tomography

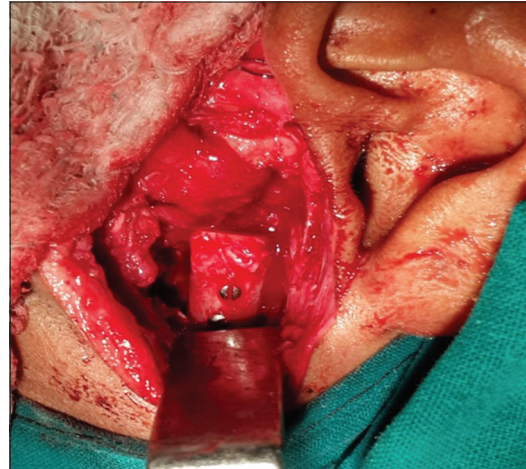


Figure 4: Intraoperative photograph showing costochondral graft fixed with 2 mm × 10 mm titanium screws

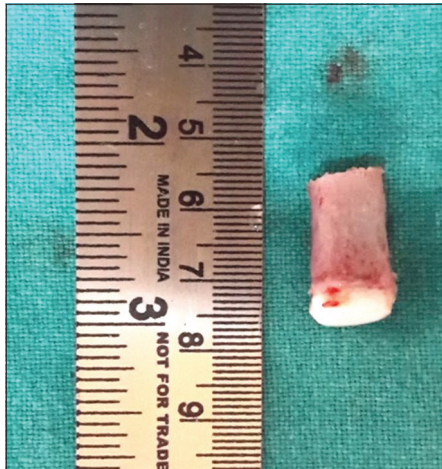


Figure 5: Photograph showing costochondral graft taken from the sixth rib

temporalis myofascial flap was rotated over the defect. Condyle was reconstructed using CCG harvested from the sixth rib fixed with 2 mm × 10 mm titanium screws [Figures 4 and 5]. Aggressive physiotherapy was advised after the day of the surgery up to 6 weeks. The patient was followed up for 5 years with

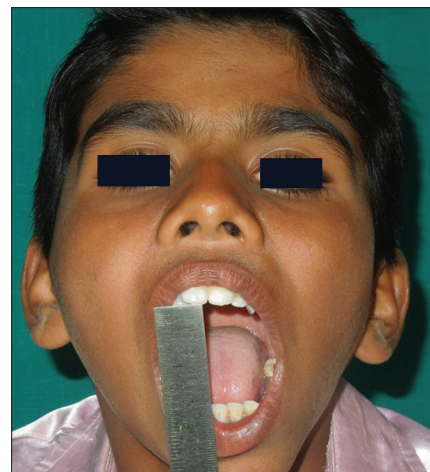


Figure 6: Postoperative mouth opening 5 years after left temporomandibular joint reconstruction

satisfactory mouth opening [Figure 6]. Remodeling of CCG into neocondyle and regrowth of coronoid process was noted



Figure 7: Five years postoperative orthopantomogram

with no obvious facial asymmetry or unpredictable growth of the mandible [Figures 7 and 8].

DISCUSSION

In growing children, CCG is a material of choice for reconstruction of TMJ because of three important functions; cartilaginous portion acts as an interpositional material, bony portion restores the vertical height of the ascending ramus, and junction between cartilaginous portion and bony portion acts as a growth center.^[1,5,7] These grafts remodel to resemble condyle overtime. Furthermore, several reports of unpredictable growth or overgrowth of mandibular CCG has been reported.^[2,8] Guyuron and Carlos (1992) concluded that the CCG has unpredictable growth pattern along with normal mandibular growth.^[1] Perrott and Kaban and Peltomaki *et al.* described two types of overgrowth such as (1) linear overgrowth resulting in asymmetric or bilateral prognathism and (2) tumor-like overgrowth and re-ankylosis and hypothesized that both types of overgrowth are caused by an excessively large cartilaginous cap on the graft. A cartilaginous cap >1–2 mm transfers an excessive portion of the growth center resulting in linear overgrowth. In some cases, micromotion occurs at the junction of the cartilage and bone during normal mandibular function which results in tumor-like overgrowth.^[4,10] In our case, symmetrical growth pattern may be due to the maintenance of 1–2 mm cartilaginous cap. Various authors also suggested that the coronoid process may reattach to form an elongated process or remain separated with the formation of the false joint with the mandibular ramus.^[9] However, we noticed regrowth of the resected coronoid process which may be due to the pull of temporalis muscle attached to it.

CONCLUSION

Management of TMJ ankylosis in growing children is challenging and requires early intervention and management with autogenous bone graft with growing potential. Meanwhile, regular and long-term follow-up is necessary till the completion of growth since there are cases of unpredictable growth pattern

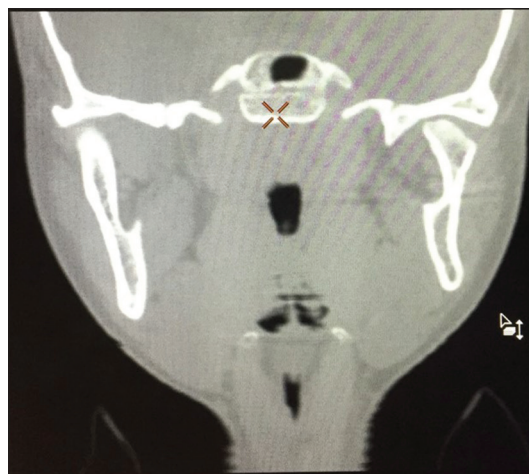


Figure 8: Five years postoperative coronal computed tomography showing the formation of the left neocondyle

of the mandible which can lead to facial asymmetry requiring further orthognathic surgery.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient's parents have given their consent for his images and other clinical information to be reported in the journal. The patient's parents understand that his name and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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