A DEFINITIVE MANDIBULAR GUIDE FLANGE PROSTHESIS FOLLOWING HEMIMANDIBULECTOMY: A CLINICAL REPORT

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ABSTRACT
Loss of continuity of the mandible destroys the balance and symmetry of mandibular function, leading to altered mandibular movements, disfigurement, difficult in swallowing, impaired speech and articulation and deviation of the residual fragment towards the surgical side. Upon opening the mouth, this deviation increases, leading to the opening and closing in the angular pathway. A corrective device named "Guide Flange Prosthesis" is indicated to limit that clinical manifestation. A new possibility for treating hemimandibulectomy patients is using an only one device both for Physiotherapy and Mastication.

KEYWORDS: Flange prosthesis; Mandibular defects; Mandibular resection; Refractory cast

INTRODUCTION
Neoplasms which are associated directly or indirectly with the mandible usually require surgical removal of the lesion and extensive resection of the bone. Loss of the proprioceptive sense of occlusion following hemimandibulectomy leads to the uncoordinated, less precise movements of the mandible. The basic rehabilitation objective is to re-educate mandibular muscles to re-establish an acceptable occlusal relationship (physio-therapeutic function) for residual mandible, so that patient could control adequately and repeatedly opening and closing mandibular movements.

Cantor and Curtis have classified the mandibular defects into 6 categories

Class III: Resection defect involves loss up to the mandibular midline region (Fig. 1c)
Class IV: Resection defect involves the lateral aspect of the mandible, but are augmented to maintain pseudoarticulation of bone and soft tissues in the region of the ascending ramus (Fig. 1d).
Class V: Resection defect involves the symphysis and parasymphysis region only, augmented to preserve bilateral temporomandibular articulations (Fig. 1e).
Class VI: Similar to class V, except that the mandibular continuity is not restored (Fig. 1f).

Numerous prosthetic methods can be employed to reduce or minimize deviation and improve functions such as Maxillo-mandibular fixation, Implant supported prosthesis, Removable mandibular guide flange prosthesis and palatal based guidance restoration.

CASE REPORT
A female patient, 36 years of age, visited the Department of prosthodontics, peoples college of dental sciences and research centre, Bhopal. The chief complaint was the unaesthetic appearance because of hemimandibulectomy, 2 years back due to squamous cell carcinoma. Intra oral examination revealed a complete absence of mandibular left segment. The defect crossed the midline and hence could be classified as Cantor and Curtis classification-III (Fig. 2a & Fig. 2 b).

An interim removable partial denture followed by a definitive cast partial denture with a guiding flange appliance was planned for this patient. For the interim prosthesis primary impression was made in alginate, followed by a dual arch impression for final cast (Fig. 3a). Jaw relation was recorded (Fig. 3b). Teeth arrangement and try in was done (Fig. 3c) and the interim prosthesis was delivered after application of tissue conditioner to the intaglio surface (Fig. 3d & Fig. 3e). For the definitive prosthesis the diagnostic cast was surveyed (Fig. 4a). Mouth preparation
Fig. 1: Cantor and Curtis Classification of Mandibular Defects

Fig. 2a: Intra Oral View of Defect

Fig. 2b: OPG Showing the Defect

Fig. 3a: Dual Impression

Fig. 3b: Jaw Relation

Fig. 3c: Try In

Fig. 3d: Interim Prosthesis

Fig. 3e: Interim Prosthesis
Fig. 4a: Surveying the Diagnostic Cast

Fig. 4b: Elastomeric Impression

Fig. 4c: Blockout of Master cast

Fig. 4b: Refractory Cast

Fig. 4e: Pre Heating of the Cast

Fig. 4b: Wax Pattern Adaptation with, Metal Bar for Guide Flange Attachment

Fig. 4f: Wax Pattern Adaptation with, Metal Bar for Guide Flange Attachment

Fig. 4g: Finished metal framework

Fig. 4h: Record base with double spacer
Fig. 4i: Impression with Tissue Conditioner

Fig. 4j: Impression with Light body

Fig. 4k: Sectioned Master cast

Fig. 4l: Checking the Adaptation

Fig. 4m: Serrations for Better Interlocking

Fig. 4n: Altered Cast

Fig. 4o: Neutral Zone Recorded

Fig. 4p: Try-In

Fig. 4q: Articulation of Maxillary and Mandibular Casts

Fig. 4r: Guide Flange Prosthesis
was done. Final impression was made in light body and the master cast was poured (Fig. 4b). Block out of the master cast was done (Fig. 4c). The master cast was duplicated in agar and refractory cast was poured (Fig. 4d). Preheating of the cast was done in the furnace (Fig. 4e). The preheated refractory cast was soaked in molten bees wax for strengthening. The preheated refractory cast was soaked in molten bees wax for strengthening. On the refractory cast the wax pattern was adapted. A metal bar was attached to the pattern for the attachment of the guiding flange (Fig. 4f). The sprues were attached, pattern was invested and casting was done. Once the casting was retrieved, it was finished and polished (Fig. 4g). To obtain the altered cast a record base was made on the minor connector with the double spacer (Fig. 4h). The final impression of the edentulous, resected, soft tissue region was taken by tissue conditioner (Fig. 4i). Over the tissue conditioner a light body wash was taken (Fig. 4j). The master cast was sectioned (Fig. 4k). The fit of the prosthesis was rechecked (Fig. 4l). For better interlocking of the two sections serrations were made on the cast (Fig. 4m). An altered cast was made (Fig. 4n). This cast was duplicated and a permanent record base was made. Jaw relation was recorded. Neutral zone was recorded to enhance stability (Fig. 4o). Teeth arrangement and try in was done (Fig. 4p). The maxillary cast was placed on the mandibular cast (Fig. 4q). For the fabrication of the guiding flange, wax extension was made on the maxillary molars (Fig. 4r). The complete assembly was cured. Final prosthesis was delivered (Fig. 4s). Marked improvement was noted in esthetics of the patient (Fig. 4t).

DISCUSSION

This clinical report illustrates the prosthetic management of a patient who underwent mandibular resection. The earlier the mandibular guidance therapy is initiated in the course of treatment the more successful the patients definitive occlusal relationship is restored. The basic rehabilitation objective in this case was to re-educate mandibular muscles to re-establish an acceptable occlusal relationship (physio-therapeutic function) for residual mandible and to restore the mastication. It also aided by controlling adequate and repeated opening and closing mandibular movements. The most common treatment modalities for such patients are maxilla mandibular fixation, implant supported prosthesis, removable mandibular guide flange prosthesis and palatal based guidance restorations. An implant supported prosthesis was not considered since no bone graft was used. The mandibular guide flange device for hemimandibulectomy patients presenting good natural teeth on the residual mandible fits...
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generally over that teeth (base-plate) and has a guide plane (flange splint) extending into the maxillary buccal vestibule, and which rides on the buccal surfaces of several of the maxillary teeth: this is the mechanical system preventing the mandible from turning toward the resected side.\[^{6,9}\] Every patient should maintain centric occlusion for mastication, and this may be accomplished by a guide plane.\[^{10}\] Using only one prosthetic device as that proposed in this work permits patients by guide flange to re-educate mandibular muscles and removing the same structure to eat. In this way patients are not obliged to use one device for the physiotherapic step and a second different device to eat. The prosthetic device proposed was easy to make and repair, comfortable to wear, also without guide flange inserted, easy to clean and functional for patient's disease so that expected results are obtained.\[^{9}\]

**CONCLUSION**

This sort of device permits the use the same prosthesis both for eating and for mechanical correction of mandibular deviation. A common feature among all removable resection prosthesis is that all framework designs should be dictated by basic prosthetic designs such as Broad stress distribution, Cross arch stabilization. A Rigid major connector stabilizing and retaining components at locations within the arch to minimize dislodgement and replacement of tooth position that optimize prosthesis.

**BIBLIOGRAPHY**


Source of Support: Nil
Conflict of Interest: Nil