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Letters to the Editor

Correction of a genioplasty

Sir,

Orthognathic surgery provides both important functional and aesthetic improvements, and this combination of outcomes is why many patients opt for it.[1] We have seen satisfactory outcomes with good management of hard tissues become compromised later, as a consequence of poor management of soft tissues. The delayed presentation of such complications means that they can be be missed on regular short-term follow up examinations.

A bimaxillary osteotomy had been done originally to correct a class II, division 1, incisor relation on a severe skeletal class II base, with associated increased vertical proportions. The patient retained an incompetent lip postoperatively, which was planned to be rectified using genioplasty. The procedure was completed with an agreeable aesthetic and functional outcome at the time, but the patient returned a year later because of increasing aesthetic concerns. The soft tissue had dimpled over the chin, which made us concerned about the position of the mentalis attachment (Fig. 1).

We revised the scar tissue and position of the mentalis, and on exploration it was clear that it had been attached too superiorly, which had resulted in a rippling effect to the chin on closure of the lip. We detached all of the mentalis muscle and associated tissue from the mandible and removed the previous anterior screws. We drilled two new holes into the inferior border of the mandible and reattached the muscle through them with 3/0 polydioxanone (PDS) sutures. The inferior attachment of the mentalis was consequently lowered to allow correct seating of the soft tissues (Fig. 2).

This case shows the importance of precise reattachment of the mentalis muscle during genioplasty, as previously highlighted by Chaushu et al,[2] and we would like to emphasise the fact that despite the poor positioning of the mentalis, initial outcomes were good aesthetically. Orthognathic follow up is not standard within the UK,[3] but we think that long-term

Fig. 1. Photograph of the patient with aesthetic concerns regarding dimpling.

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Fig. 2. Photograph after the corrective surgery with a repositioned mentalis muscle.

monitoring of the attachment of soft tissues may be indicated in such circumstances.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patient's permission

Ethics approval not required. The patient gave consent for the use of the images.

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Re: Condylectomy: treatment of recurrent unilateral dislocation of the temporomandibular joint in a patient with Ehlers-Danlos syndrome

Sir,

We would like to comment on the interesting article by Campbell et al[1] and compliment them on their successful use of condylectomy to treat a dislocation of the temporomandibular joint (TMJ). While they discussed the surgical methods for the treatment of dislocation of the mandible, they did not analyse publications on the subject, and failed to mention minimally-invasive approaches.

Machon et al[2] reported the injection of autologous blood into the TMJ, which resulted in the formation of fibrous tissue and, ultimately, in stiffness of the joint. To the best of our knowledge, Ohnishi was the first to describe arthroscopy for the treatment of recurrent dislocation using posterior scarification with arthroscopic suturing of the disc to limit movement of the condyle.[3]

Many other arthroscopic techniques have also been reported, such as sclerosis of the oblique protuberance by injecting sclerosing agents, or electrocautery of the oblique protuberance to obtain retrodiscal scarification and inhibit forward motion of the condyle and disc. As far as we know, arthroscopic eminoplasty was used for the first time by Segami et al in 1999 to treat recurrent dislocation of the TMJ.[4]

The overall success rate for various arthroscopic procedures ranges from 82% to 95%.

Sembronio et al reported their experience in arthroscopic management of TMJ dislocation with a combination of two procedures, which were capsulorrhaphy and retrodiscal tissue cauterisation (Fig. 1) in conjunction with eminoplasty (Fig. 2) to obtain a scarification in the upper joint space, and a reshaping of the upper joint compartment by reduction of the articular eminence.[5] In our series of patients, which included 19 cases between 2010 and 2016, the success rate was 95% and three had Ehlers-Danlos syndrome.