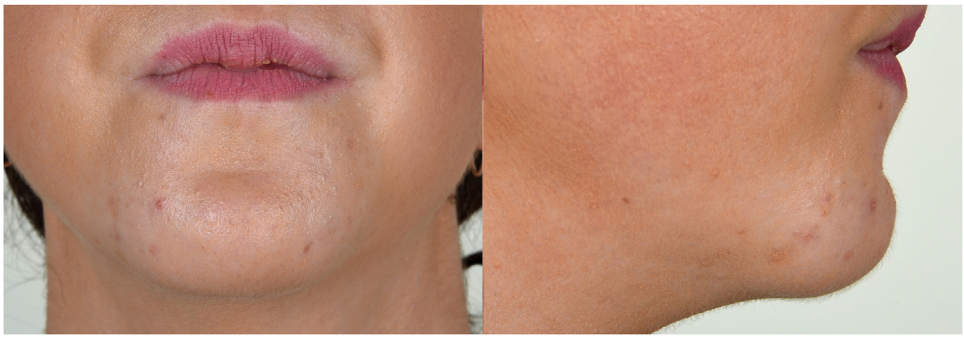

Fig. 2. Photograph after the corrective surgery with a repositioned mentalis muscle.

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.

References

1. Rustemeyer J, Eke Z, Bremerich A. Perception of improvement after orthognathic surgery: the important variables affecting patient satisfaction. *Oral Maxillofac Surg* 2010;**14**:155–62.
2. Chaushu G, Blinder D, Taicher S, et al. The effect of precise reattachment of the mentalis muscle on the soft tissue response to genioplasty. *J Oral Maxillofac Surg* 2001;**1**:510–6.
3. Parbatani R, Williams AC, Ireland AJ, et al. The process of orthognathic care in an NHS region. *Ann R Coll Surg Eng* 2010;**92**:34–9.

T. Dennis
A. Bains*
D. Doumpiotis
Wythenshawe Hospital, University Hospital of South Manchester, Southmoor Road, Wythenshawe, Manchester, M23 9LT
* Corresponding author.
E-mail addresses: tom.dennis@nhs.net (T. Dennis), amandeep.bains1@nhs.net (A. Bains), ddoumpiotis@nhs.net (D. Doumpiotis)
Available online 26 April 2019
https://doi.org/10.1016/j.bjoms.2018.10.288

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.

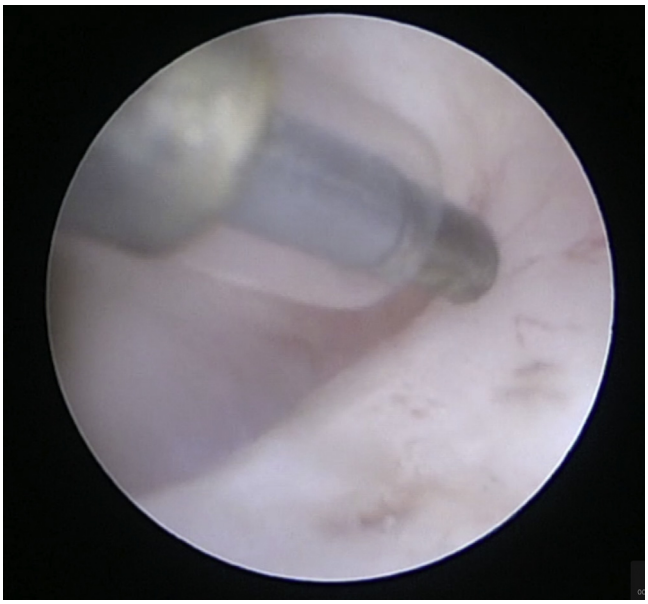

Fig. 1. Arthroscopic view of scarification of retrodiscal tissues using radiofrequency.

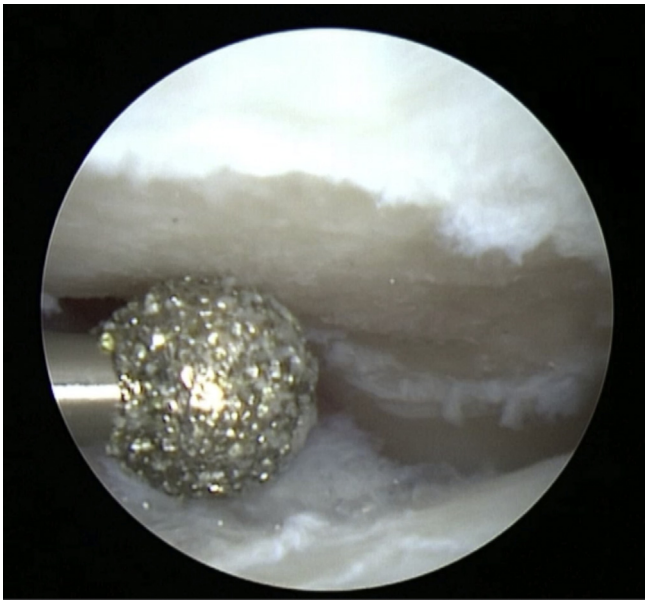

Fig. 2. Arthroscopic view of the reshaping of the articular eminence with a diamond burr.

We would have preferred it if Campbell et al had not stated that condylectomy avoids the morbidity associated with other procedures, because their experience is based on only a single case report, and other complications have been reported that are related to the open approach, such as facial palsy or scarring.

We would like to remind them that the risk of malocclusion is also reported for unilateral condylectomy. To use their own comparison, it is widely known that patients who have condylectomy for hemimandibular hyperplasia have a postoperative malocclusion with precontact because of loss of height on the side of the condylectomy.

They used an orthopantomogram in their study, but we think that magnetic resonance imaging is necessary in postoperative follow up to analyse the dynamics of the disc-condyle complex and how dislocation of the TMJ can be avoided. We studied patients who had had arthroscopic eminoplasty and confirmed that the procedure limits the translation of the disc-condyle complex according to a block procedure.

In the conclusion to the paper, the sentence "unilateral condylectomy to treat unilateral recurrent dislocation of the TMJ may be considered as a first-line treatment" is excessively strong and open to criticism.

Previous publications should not be ignored, and our suggestion therefore is to use less invasive procedures first, and then take further steps as necessary.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patients' permission

Ethics approval is not necessary. All patients provided consent.

References

1. Campbell SJ, Chegini S, Heliotis M. Condylectomy: treatment of recurrent unilateral dislocation of the temporomandibular joint in a patient with Ehlers-Danlos syndrome. *Br J Oral Maxillofac Surg* 2019;**57**: 76–8.
2. Machon V, Abramowicz S, Paska J, et al. Autologous blood injection for the treatment of chronic recurrent temporomandibular joint dislocation. *J Oral Maxillofac Surg* 2009;**67**:114–9.
3. Ohnishi M. Arthroscopy for hypermobility and recurrent dislocation. *Oral Maxillofac Clin North Am* 1989;**1**:1 (Cited in: McCaine JP. *Principles and practice of temporomandibular joint arthroscopy*. Mosby 1996).
4. Segami N, Kaneyama K, Tsurusako S, et al. Arthroscopic eminoplasty for habitual dislocation of the temporomandibular joint: preliminary study. *J Craniomaxillofac Surg* 1999;**27**:390–7.
5. Sembronio S, Russillo A, Giannì AB, et al. Arthroscopic management of TMJ dislocation. In: Matthews NS, editor. *Dislocation of the temporomandibular joint*. Springer International Publishing AG; 2018. p. 91–103.

S. Sembronio *
A. Tel

M. Robiony
Maxillofacial Surgery Department, Academic Hospital of Udine, Department of Medicine, University of Udine
* Corresponding author at: Maxillofacial Surgery Unit, Academic Hospital of Udine, Department of Medicine University of Udine, P.le S. Maria della Misericordia 1, Udine, 33100
E-mail address: info@sembroniomaxillo.com
(S. Sembronio)
Available online 13 April 2019
https://doi.org/10.1016/j.bjoms.2019.03.019

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

Sir,

In response to the letter to the editor on our article entitled "Condylectomy: treatment of recurrent unilateral dislocation of the temporomandibular joint in a patient with Ehlers-Danlos syndrome"[1] we thank Sembronio et al[2] for their constructive comments. We apologise for not having referenced endoscopic techniques in our report, and we thank them for making us aware of their work.

In our opinion, disc plication, either open or closed, would not have been appropriate in this case. The dislocation was a result of the anatomical relation of the condyle to the deeply set fossa rather than the disc. The disc placation or eminectomy techniques described in the letter, therefore, may have not been appropriate in this case.

Our patient has been free of symptoms, and has regained full function and occlusion. MRI imaging is not necessary therefore for follow up, as all symptoms have fully resolved. Regarding occlusion, as a result of our protocol of intermaxillary fixation, the senior author has not experienced malocclusion in 11 cases of high condylectomy.

In summary, current established practice is based on series of case studies, some of which are decades old. We presented a case that had been managed differently to the set dogma of eminectomy, infracture of the zygomatic arch, and repositioning of the disc. Our technique resolved the disabling dislocation with full restoration of function and no complications.

Ethics statement/confirmation of patients' permission

Not applicable.

Conflict of interest

We have no conflicts of interest.

References

1. Campbell SJ, Chegini S, Heliotis M. Condylectomy: treatment of recurrent unilateral dislocation of the temporomandibular joint in a patient with Ehlers-Danlos syndrome. *Br J Oral Maxillofac Surg* 2019;**57**:76–8.
2. Sembronio S, Tel A, Robiony M. Re: Condylectomy: treatment of recurrent unilateral dislocation of the temporomandibular joint in a patient with Ehlers-Danlos syndrome. *Br J Oral Maxillofac Surg* 2019 (In press).

S.-J. Campbell
DCT2 OMFS Northwick Park hospital, 46 Acorn walk, SE16 5EP, London
S. Chegini *
M. Heliotis
Northwick Park hospital
* Corresponding author.
Available online 6 April 2019
https://doi.org/10.1016/j.bjoms.2019.03.018

Congenital epulis: a rare case of feeding obstruction in a neonate

Sir,

Congenital epulis, also known as congenital granular cell tumour, is a rare, benign, neoplastic lesion of the newborn. It is often found on the anterior maxilla, has a strong female:male predilection (10:1) with a classic granular histopathological appearance.[1,2] It is recognised as an uncommon cause of feeding obstruction in neonates.[2]

We present a case of a large, congenital epulis that obstructed feeding in a newborn child.

A 4-day-old baby girl was referred to the department with a lesion on the anterior maxilla that interfered with her feeding. She was born at term after an uncomplicated pregnancy, was otherwise fit and well, and thought to be feeding satisfactorily before she was discharged from hospital. The mother attended a scheduled appointment shortly after the birth, and expressed concerns about the baby's ability to achieve an adequate oral seal while feeding.

On examination a large, pedunculated, firm, smooth, regular mass that measured 20 × 10 mm was seen at the anterior maxillary alveolus. A congenital epulis was suspected, so we infiltrated a small volume of local anaesthetic with adrenaline, applied a surgical vascular tie (Fig. 1), excised the lesion, and left the base to granulate.

Histopathological examination showed a lesion composed of sheets of large polygonal cells with eosinophilic granular cytoplasm, small central nuclei, and occasional odontogenic rests, and confirmed the diagnosis of congenital granular cell tumour (congenital epulis).

The baby was reviewed three weeks later. The excision site had completely healed and her mother commented on a pronounced improvement in feeding with an appropriate gain in weight (Fig. 2).