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Research Article

A VERSATILE MODIFICATION OF PALATAL FLAP FOR CLOSURE OF ORO ANTRAL FISTULA

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ABSTRACT

The literature is full of various techniques to close oro antral communication. Various local and distant flaps are available with or without graft materials to treat the same. In local flaps we can use buccal flap, palatal flap or combination of both. In the present case, we modified the palatal advancement flap to close the oro-antral communication.

INTRODUCTION

Oro antral communication is a well-known complication post trauma, post-surgery, after upper third molar disimpaction, extraction, radiation, infection, cyst or neoplasm.[1] The literature is full of various techniques to close oroantral communication. The choice of each of these procedures is influenced by size of the defect, location of the defect, any previous attempt and the condition of the tissue available for the repair.[1] Various local and distant flaps are available with or without graft materials to treat the same. In local flaps we can use buccal flap, palatal flap or combination of both. Palatal flap had been further classified as straight advancement, island flap, hinged flap, rotational advancement flap, submucosal connective tissue pedicle flap and submucosal island flap.[4] Palatal flap is less elastic, but they are thicker than buccal tissue, simple and versatile and mobility of the palatal flap is reasonable. The abundant blood supply to the palatal tissue promote satisfactory healing of the flap. The added advantage of the palatal flap is that they don't affect the buccal vestibule height and is associated with minimal discomfort during healing[1, 2, 3, 4]. In the present case; we modified the palatal advancement flap to close the oro-antral communication (OAC).

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CASE REPORT

A 48 years old male reported to our department with a chief complaint of regurgitation of fluid through nose post extraction of right side upper first and second molar at a private dental clinic (figure 1).

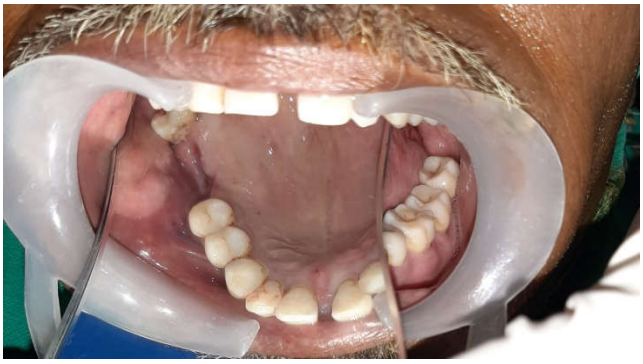

Figure 1 Intra oral pre- operative picture

Closure of OAC was done on the same day with buccal advancement flap and buccal pad of fat immediately after extraction, but patient was not relieved. Patient had been explained regarding the palatal rotation flap and the secondary healing area on the palate, but patient denied considering it. Considering the patient psychology, the decision was taken to use modified technique to reduce the post-operative discomfort and healing time. Patient was operated under local anaesthesia, the fistula was excised with the 11 no blade and the granular tissue was curated, crevicular incision was given at the palatal

site and a parallel incision was given towards the midline beyond the greater palatine artery, full thickness mucoperiosteal flap elevation was done and the flap was tunnelled and repositioned buccally (figure 2 & 3).

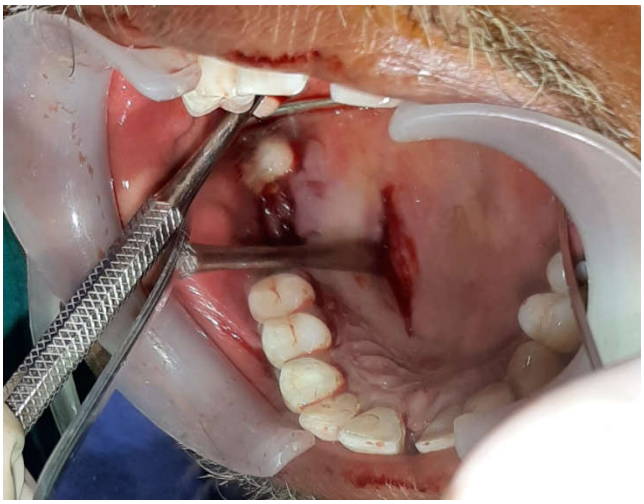

Figure 2 Intra operative picture showing the parallel incision towards the midline.

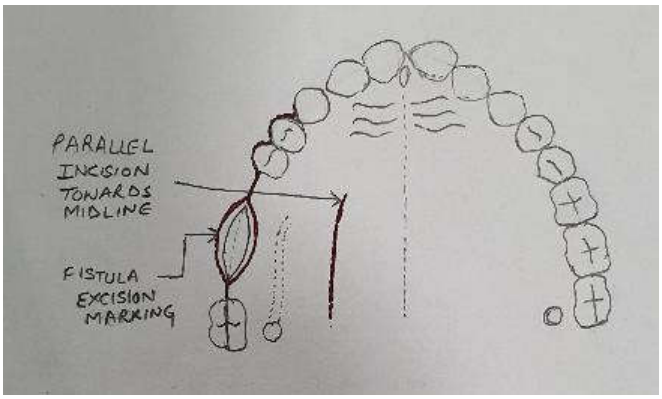

Figure 3 Diagrammatic presentation of incision

Vertical mattress sutures were given with 4-0 silkand the sutures were removed on 10th day post operatively. The patient was followed up for one month (figure 4).

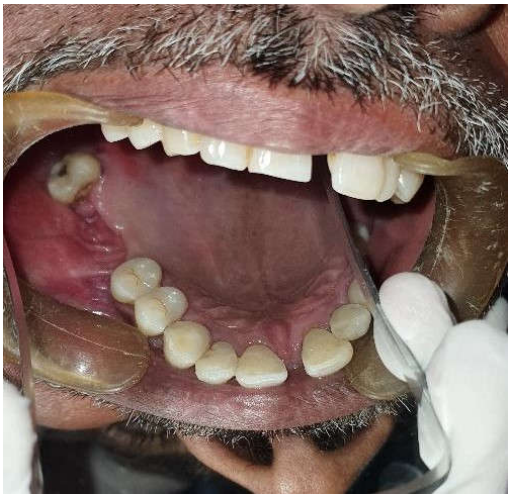

Figure 4 Intra oral one-month post-operative picture

CONCLUSION

The above mentioned technique for closure of OAC is a modification of previous lateral sliding technique with satisfactory results.

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Conflict of interest

None

Ethical approval

Not required

Patient consent

Written consent was obtained prior to case.

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