

## WFHS BUSINESS MEETING

At the end of the case presentation portion of our Zoom meeting on December 5, Dr. Claudine Cafferata invited all the WFHS Board members and any other interested participants in the Zoom meeting to join us for a brief business meeting. It started off with a favorable analysis of the case presentations. There were over 60 participants in the meeting and there were several good questions and comments from participants for the presenters. Gratitude was expressed for the efforts of the programs to make this possible. The plans for next year's meeting were addressed and the consensus was that it will be months before we will be able to determine whether we will be able to have a normal annual meeting even for next November. It may be that we will have to resort to a virtual meeting again next year if

the vaccine program does not fulfill its promises. Many expressed their prejudice to having our normal live meeting if at all possible. Hopefully, we will be able to make that decision next spring. It was mentioned that we may consider moving next year's meeting date to the spring of 2022 if we cannot meet in November 2021. We will confirm that the Harrigan Awardee scheduled for 2020 (Dr. Bill Nelson); he will be approached about accepting the 2021 Award. The WFHS Board will remain the same for next year with the exception that Dr. Lee Kojanis will be asked to take over the education directorship. Dr. Dolan reported that the treasury is in good shape since we have had little expenses due to the pandemic. He also said that the treasurer's job is being moved to Dr. Cafferata and Dr. Miranda.

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# Newsletter

## RESIDENT'S CASE PRESENTATIONS

**O**N DECEMBER 5, 2020 WE HAD OUR FIRST EXPERIENCE

with having residents from our three core programs give case presentations over a Zoom meeting. Over 60 people joined the meeting. We owe thanks to the residents and their mentors who made this possible. While we all miss the social contact and excitement of our live meetings in NYC, this gave all of us an opportunity to listen to the three residents and participate in critiquing the cases. I want to specifically mention Dr. Karlis and Dr. Nannini and Dr. Bastidas and their staffs for making this possible.

I also want to acknowledge Dr. William Koniki who handled most of the logistics.

Dr. Vasiliki Karlis opened the meeting with a welcome. She wanted to comment on the recent passing of one of her former residents, Dr. Ramkumar Katikaneni who succumbed while undergoing chemotherapy for lymphoma in Houston where he was in practice. Dr. Karlis mentioned that he originally came from India and followed a long process that culminated in his graduation from the Bellevue OMFS program in 2012. Hunter Martin and Chi Viet also commented on their contact with him while in training and noted his compassion and dedication.



While we were waiting for the residents' portion to begin, Dr. M. Wiltz spoke about the Montefiore program. He said that Dr. Richard Kraut has retired after 30 years as head of the OMFS program at Montefiore. Dr. Thomas Helfst will be taking over as the new head of OMFS at Montefiore. Dr. Helfst comes from a successful practice in Pennsylvania and is looking forward to continuing their association with the WFHS group. Dr. Wiltz acknowledged Dr. Kraut's contributions and added that they are seeking to add new staff members to the program.

**D**R. WILLIAM KONICKI FROM BELLEVUE OPENED THE

general meeting with a case of a 72 year old female of Chinese descent who presented to their service with a painful lesion on the right lateral tongue that the patient thought had been there for several months. An incisional biopsy was done which was reported out as squamous cell carcinoma. Clinically, it was a little over 2 cm in diameter and was exophytic and friable. It extended from the right lateral tongue into the right floor of mouth. There were no palpable cervical nodes. A CT scan confirmed the 23 by 8 mm size and showed

(Continued)



## Residents' Presentations cont.

no bony invasion or nodal involvement. A chest xray showed clear lung fields.

The proposed treatment plan was for a partial glossectomy and a partial neck dissection. Some of the morbidity expected was for decreased swallowing and impaired speech although this would be made worse if radiation treatment was required. If the glossectomy is limited to less than 50% of the tongue, the prognosis is better. The treatment of the surgical void is a choice between primary closure and flap reconstruction. Primary closure is associated with less post operative morbidity, but gives more long term morbidity such as impaired tongue mobility and speech difficulties. The choice of origin for the flap surgery is between axial flap rotation or submental island flaps. They chose to use the submental island technique which was first described in 1993. With this surgery, the submental skin and underlying tissue is pedicled on the submental artery and vein and sometimes the digastric muscle. The laxity of the skin determines the generosity of the tissue available. There is a danger of transferring metastatic cells in this procedure. In this case, they incised a 6 x 3.5 cm graft with the right anterior digastric muscle and an extension of the incision to the right submaxillary gland area allowing for a partial neck dissection. A temporary clamp was placed on the right submental artery during surgery. Cervical nodes removed were submitted for frozen section; they came back as negative. The patient's post operative course was benign and no radiation was deemed necessary. There was no incidents of aspiration and swallowing was not greatly effected.

Dr. MacIntosh commented that including the belly of the digastric muscle gives increased bulk to the graft which is favorable. He favors incision of the digastric muscle at its insertion point with careful handling of its blood supply. Some surgeons just divide the muscle and then re-connecting it after moving it into place. He said it is hard to determine at surgery if any impaired tongue function will be temporary or permanent. Dr. Vasiliki commented that the submental island muscle flap is a good alternative but she prefers the microvascular graft if feasible and prefers the forearm free flap over the supraclavicular



flap. Dr. Koniki noted that the submental graft allows extension into the neck dissection. He also mentioned that flap contraction is part of the morbidity of this procedure.

**D**R. ELLIOT SALEH, WHO IS AN INTERN at Montefiore, presented "Surgical Management of an Intra-osseous Hemangioma in a Child." This case involved a well developed and well nourished four year old female who presented with an expansile lesion of the right mandible with symptoms of pain and bleeding. There was fullness of her lower right face and buccal and lingual expansion of her mandible and mobility of several teeth in this area as well as some displacement of teeth. Xray demonstrated a multilocular lesion of the right mandible. The differential diagnoses was (1)central giant cell lesion; (2)ameloblastic fibroma; (3)hemangioma; or (4)granulomatosis. Needle aspiration resulted in 11 to 12 cc of blood and the aspiration procedure was aborted. MRI's were obtained that showed the multilocular nature of the lesion. Interventional Radiology was brought in and they performed arteriography under general anesthesia to determine the vessels that were feeding the lesion. Selective injection of the right lingual artery showed it to be normal, but the right inferior alveolar artery showed as the main feeder vessel. They then embolized this and any other vessels in the area until control was achieved. They also used coils in addition to embolized solid materials. The patient was then taken directly to the operating room while still anesthetized and a mucoperiosteal flap was raised from the right mandibular alveolus. The soft tissue lesion was then removed as well as involved

teeth and then the void was grafted with artificial bone material. There was blood loss estimated at 300 cc but the patient was stable and no transfusion was done. The pathology report came back as central interosseous hemangioma. The literature shows 86 reported cases of this entity in the facial bones with a usual age range in the twenties. Treatment modalities include radiation, sclerosing agents and resection. Their patient is now three years post op and the healing is normal. Their plan is to use an appliance to prevent extrusion of maxillary teeth and to replace missing mandibular teeth with implants when she is older.

Dr. Williams asked whether the aspirated blood was of low or high flow. Dr. Saleh said it was of low flow volume. Dr. Williams suggested that it was more likely to be an arteriovenous malformation than a hemangioma. Another practitioner asked for their rationale for doing a bone graft to the area at this age when it may have healed without a graft. Dr. Saleh said they thought it would heal better with a graft. It was noted that the use of heterogenous bone material was preferred over homologous material since no additional surgery was needed to secure the material.



**D**R. IAN LEHRER FROM NASSAU UNIVERSITY MEDICAL Center presented "An Essential Service: The Case of Trauma Portugal". This was an effort to highlight the essential nature of OMS specialists for Level 1 Trauma Centers. Their case involved a 26 year old male with an unknown past medical history who was brought to the ER after a motor vehicle accident. The patient was unconscious and presented clinically with massive trauma to the facial and head areas. He was intubated upon arrival in the ED. Exam showed unstable mandible and maxilla, facial lacerations, nasal crepitus, bilateral steps in the infra-orbital rims, lacerated hard palate, and missing and damaged anterior teeth. Imaging showed right frontal and left temporal lobe hemorrhage and several small subdural hematomas but no shift in the midline. The MRI showed darker areas in the frontal area of the brain which were diagnosed as areas of de-oxygenated hemoglobin and confirmed the diagnosis of diffuse axonal injury. After evaluation by the neurosurgery team, the neurosurgeons performed a twist drill craniostomy done to allow CSF drainage to relieve cranial pressure.

The facial injuries were diagnosed as bilateral Lefort 3 fractures, fractured right zygomatic arch, fractured orbital floors, fractured hard palate, nasoorbital ethmoidal fractures, bilateral mandibular parasymphaseal fractures and right subcondylar fracture.

The facial treatment plan executed starting with a bottom up approach for treatment of the facial fractures. IMF was placed with upper and lower arch bars and then a submental incision was made to get to the

anterior mandibular fractures. This showed poor reduction from the IMF and so they released the fixation and reduced the fractures manually, re-secured the lower arch bar and IMF with screws and plating. Bilateral lateral brow incisions were made to access the bilateral zygomaticofrontal fractures and a bilateral vestibular incision was then made to visualize the bilateral zygomaticomaxillary buttress fractures. The zygomaticofrontal and zygomaticomaxillary buttress fractures were plated and the zygomatic arches were both reduced. They then did a closed nasal reduction. They did a forced duction test to rule out

any extraocular muscle entrapment. The patient had an uncomplicated recovery and was discharged to a traumatic injury recovery center where care was coordinated with inhouse physical therapists and OMS staff with the NUMC OMS department. The IMF was removed in two weeks and elastics were placed to allow condylar adaptation to the new anatomical position. The MIO was 30mm at that point. Dr. Lehrer noted that a screw had been placed in the anterior maxillary alveolus to allow fixation for a wired attached to the arch bar so that it wouldn't be displaced downward.

Phase 2 of the treatment involved the placement of implants, in a fully guided fashion, for a fixed bridge in the area of the anterior maxilla where several teeth had been lost. The MIO at that point was 35 mm.

Dr. Lehrer pointed out that the OMS has the training to not only treat facial trauma, but also plan interventions with the end result in mind, including the dentition.

This case highlights a successful end results that is comprised of restoration of facial height, facial projection, and eventually the dentition.

This ground-up and all-inclusive approach is what sets the OMS apart from other facial trauma providers. This merits OMS as an essential service to the trauma team for level 1 status.

A question was raised concerning the orbital floor and infra-orbital rim fractures. Dr. Lehrer said that these fractures were reduced well without the need for direct fixation and said that the subcondylar fracture did not have a large enough proximal segment to hold plate fixation.