DENTISTRY

18th
Scientific Meeting
and Refresher Course
in Dentistry

KPPIKG

JAKARTA CONVENTION CENTER
10-13 OCTOBER 2019

IWDR
ISCaRD

IN CONJUNCTION WITH:
4TH INTERNATIONAL WORKSHOP ON DENTAL RESEARCH
2ND INTERNATIONAL SEMINAR ON CLINICAL AND RESEARCH IN DENTISTRY

CONTENTS

LIST OF COMMITTEE KPPIKG 2019

Councelor Advisor	Prof. Dr. Ir. Muhammad Anis, M. Met Prof. Dr. M. F. Lindawati S. Kusdhany, drg, SpPros(K) Prof. Dr. Ellyza Herda, drg, M.Si Dr. Retno Widayati, drg, SpOrt(K) Dr. Anggraini Margono, drg, SpKG(K)
Steering Committee	
Chairman	Dr. Eva Fauziah, drg, SpKGA(K)
Secretariat Team	Nieka A. Wahono, drg, PhD, SpKGA(K) Ike Dwi Maharti, drg, SpKG Ruslina, S.Sos Maulidia, A.Md Lusiana Puspita Sari, Amd Juli Kusdwiastini, S.AB Neneng Tarwiyah, SE Ranny Herdiantoputri , drg Cymilia Gityawati , drg Regina Vaniabella, drg Tri Kurnia Dewi, drg Intan Detrianis Nadia Safira Ninda, drg Avi Aisyah Nabila Ekayani Calfina
Information	Kiatra Vasthi Nadira Lila Fairuz Hanaa
Marketing & Publication Coordinator Team	Fakhrana Ariani Ayub, drg, SpPros Suswandoyo Biyoga, SE, MSi Lita Septira, S.I.Kom Annisa Widiandini Chika Astasari Hadi Widya Aryani Septi Dwi Alvian Ahmad Syaukani, drg, Sp.Ort Sandra Mega, drg, SpOrto Fadil Wicaksana
Treasurer Coordinator Team	Sariesendy Sumardi, drg, SpOrt(K) Syurri Innaddinna Syahraini, drg, MBiomed Laila Sari Nurhasanah SE Yuyun Damayanti, AMd Leila Susy

	Nur Asiah, SAB
	Kartika Sri Kusumastuti , drg
	Liesma Dzulfia , drg
Registration	
Coordinator	Herlis Rahdewati, drg, SpPerio
Team	Ariyanti Rezeki, drg, SpPros
	Puji Astuti, SE
	Dimas Ilham Utomo, drg, SpPerio
	Namira Rositha Hakiki , drg
	Bella Nadya Permana , drg
	Atik Ramadhani, drg, PhD
Scientific Program	
Head of Scientific Program	: Dr. M. Fahlevi Rizal, drg, SpKGA(K)
Proceeding Coordinator	Erik Idrus, drg, PhD
	Merry Elisa, drg
Main Lecture Coordinator	Bramma Kiswanjaya, drg, PhD
	Melissa Adiatman, drg, PhD
Team	Rahmatul Hayati, drg
	Nurrachma Hakim
	Dovian Emely
	Belladina Maulani, drg
	M. Revaldi, drg
	Nevada Permata
	Atikah Amalina
	Beta Belatrix
	Tsabita Adeilina
	Shilvy
	Cut Asyila Vianda
	Getha Gazela
	Lutfi Laili
	Nadhira Haifa
	Nourma Nurillah
	Aisyah Mauludia, drg
	Rosi Sriandita, drg
	Rifa Gumay, drg
	Aulia Karina
	Hardiati Nur Wahyuni
	Renya Virga
	Alma Mutiarani
	Naryndra Nastiti
	Qonita Feria
	Mutia Nafisah
	Annisa Ghaisani
	Tsany Saadi
	Dhia Safira

	Nur Asiah, SAB
	Kartika Sri Kusumastuti , drg
	Liesma Dzulfia , drg
Registration	
Coordinator	Herlis Rahdewati, drg, SpPerio
Team	Ariyanti Rezeki, drg, SpPros
	Puji Astuti, SE
	Dimas Ilham Utomo, drg, SpPerio
	Namira Rositha Hakiki , drg
	Bella Nadya Permana , drg
	Atik Ramadhani, drg, PhD
Scientific Program	
Head of Scientific Program	: Dr. M. Fahlevi Rizal, drg, SpKGA(K)
Proceeding Coordinator	Erik Idrus, drg, PhD
	Merry Elisa, drg
Main Lecture Coordinator	Bramma Kiswanjaya, drg, PhD
	Melissa Adiatman, drg, PhD
Team	Rahmatul Hayati, drg
	Nurrachma Hakim
	Dovian Emely
	Belladina Maulani, drg
	M. Revaldi, drg
	Nevada Permata
	Atikah Amalina
	Beta Belatrix
	Tsabita Adeilina
	Shilvy
	Cut Asyila Vianda
	Getha Gazela
	Lutfi Laili
	Nadhira Haifa
	Nourma Nurillah
	Aisyah Mauludia, drg
	Rosi Sriandita, drg
	Rifa Gumay, drg
	Aulia Karina
	Hardiati Nur Wahyuni
	Renya Virga
	Alma Mutiarani
	Naryndra Nastiti
	Qonita Feria
	Mutia Nafisah
	Annisa Ghaisani
	Tsany Saadi
	Dhia Safira

	Ferditya Harley P
	Morina Leoni Himra
	Preticia Lee
	Ari Stevanofiq
	Vania Mariska
	Abdul Robby Farhan
Food & Beverage	
Coordinator	Lia Kartikasari, drg, PhD, SpPros(K)
Team	Astri Kusumaningrum, drg, SpKGA
	Rezki Viona, drg, SpKGA
	Dina Helmaya Anisja, drg
	Citra Mutiah Sari, drg
	Miana Laili
	Farahdillah, drg
	Fidhianissa, drg
	Devina Rahma, drg
	Muhammad Hanif Munandar
	Rivandy Holil
	Anindita Prima
	Muhammad Dhiaulfikri N H
	Donovan Roberto Jonamika
	Dwi Putra Ramadhan
	Giovanni
	Dina Septia
	Satriyo
Equipment	
Coordinator	David Maxwell Sagala, drg, SpPros
Team	Achmad Fadillah, S.Si
	Imam Sifantoro Suryo Budiman, S.E.
	Yuli Asih, A.Md. Ak
	Ahmad Romdhoni
	Sukeri
	Muhammad Naufal
	Bintang Agus Setiawan
	Nastiti Rilo Utami, S.Si
	Astri Deviana, S.Si
	Annisa Dien Andriyani, S.Si
	Bernard Kurniawan, drg
	Rezon Yanuar, drg
	Bima Surya , drg
	Anastasia Gabriela Liem
	Stifan Jamin
	Mikail
	Aldriyety Merdiarsy
	M. Hasan Jihad
	Damario Augustovan Effendy
	Priscilla Clarissa

Hastinefia putri
Diksi Priyono
Wiliam Carlos
Sammy Fajar Nugraha

Transportation & Accomodation
Coordinator
Team

Aloysius Putut, drg
Boskoardy
Nia Nathania

Liason Officer
Coordinator
Team

Shalina Ricardo, drg, SpKG
Marcos Fung
Kartika Devy Pragitara
Nola Primadona
Faiz Abdurrahman
Darwin Yunaidy
Qaiszara Puspadewi
Dwi Retno Anggraeny
Syifa Mudhia Yusuf
Marceline Olivia
Levina Nathania
Anastasia
Rakanda Rizki Ramadhani
Deajeng Laras H
Fadiza Fadillah Nurchasanah
Ghina Sharfina
Vania Mariska Putri
Danny Tandean
Johan Adiyasa
Rona Laras Narindra
Lulu Sharfina
Rebecca Grace Agustina
Glenda Clarissa Swandy
Indira Annisa Sophia
Nadine Khalissya

Security

Kuat
Ardy
Fadjar Seno Adji
Marselinus Duapadang
Nadia Shabrina
Alri Bakti Wiratama
Cinta Nurindah Sari
M Viko Aufar
Awi Rexi Ginting
Satya Vraken
Obed Timotius
Riza Hakim F. Zaini

Reviewer	Bramma Kiswanjaya, drg, PhD Prof. Dr. Margaretha Suharsini S, drg, SU, SpKGA(K) Fatimah Tadjoedin, drg, SpPerio(K) Prof. Dewi Fatma Suniarti, drg, MS, PhD Diah Ayu Maharani, SKG, drg, PhD Indriasti Indah Wardhany, drg, SpPM(K) drg. Muslita Indrasari, M.Kes., Sp.Pros(K) drg. Siti Triaminingsih, M.T.
Scientific Award Judges	Prof. Dr. Margaretha Suharsini S, drg, SU, SpKGA(K) Fatimah Tadjoedin, drg, SpPerio(K) Prof. Dewi Fatma Suniarti, drg, MS, PhD Indriasti Indah Wardhany, drg, SpPM(K) Dr. Cortino Sukotjo, DDS, Ph.D, MMSC Edwin M. Ongkosuwito, PhD, DDS

LIST OF COMMITTEE 4th IWDR

Advisor	Prof. Dr. M.F. Lindawati S. Kusdhany, drg., Sp.Pros(K)
Scientific Coordinator	Prof. Dr. drg. Ellyza Herda, M.Si
Fund Coordinator	Dr. drg. Retno Widayati, Sp.Ort(K)
Chairman	Drg. Lisa Rinanda Amir, PhD
Secretaries	Drg. Citra F. Theodorea, M.Si., PhD Ismartiny
Treasurer	Drg. Anandina Irmagita, Sp.PM(K) Lailasari
Publication & Documentation	Lita Septira, S.I.Kom
Conference Manager System	Drg. Fakhrana Ariani Ayub, Sp.Pros Drg. Ninis Yekti Wulandari Achmad Fadillah, S.Si
Member	Drg. Syurri Innaddinna Syahraini, MBiomed Sukeri

LIST OF COMMITTEE 2nd ISCARD

Advisor	Prof. Dr. M.F. Lindawati S. Kusdhany, drg., Sp.Pros(K)
Scientific Coordinator	Prof. Dr. drg. Ellyza Herda, M.Si
Fund Coordinator	Dr. drg. Retno Widayati, Sp.Ort(K)
Chairman	Dr. Yuniardini S. Wimardhani, drg., MSc.Dent.
Secretaries	Drg. Ambar Kusuma Astuti, Sp.PM Ismartiny
Treasurer	Lailasari Yuyun Damayanti, A.Md
Publication & Documentation	Suswandoyo Biyoga, S.E., M.Si
Conference Manager System	Drg. Fakhrana Ariani Ayub, Sp.Pros Drg. Ninis Yekti Wulandari Achmad Fadillah, S.Si
Members	Sukeri Rossi Maolana A.Md

DAY 2

POSTER PRESENTATION
Screen 1

Friday. 11th October 2019
13.00-14.30

No	No. Poster	Paper Title	Author
1	P2-01B-01	Brain Abscess Due to Odontogenic Infection in a Child (Case Report)	Rani Handayani, Achmad Jana Maulana, Paulina Thiomas Ulita, Nila Kencana Sari, Afia Afanty
2	P2-01B-02	Unilateral TMJ Prosthesis after Segmental Mandible Resection and Disarticulation Case Series	Rumartha Putri Swari Evy Eida Vitria Wenny Yulvie
3	P2-01B-03	Post Operative Complications in Patient with Palatoplasty Procedure A Case Report	Winantu Yuli Asri Evy Eida Vitria Eky Nasuri
4	P2-01B-04	Surgical Management of Large Calcifying Epithelial Odontogenic Tumor (CEOT) of the Mandible A Case Report	Wayan Hari Swarjaya Sandi Wenny Yulvie Evy Eida Vitria
5	P2-01B-05	Management of Hemangioma in a Child with Nephrotic Syndrome A Case Report	Indriati Evy Eida Vitria Eky Nasuri
6	P2-01B-06	Bilateral Sagittal Split Osteotomy for Management of Mandibular Prognathism with Deep Bite and Midline Shifting	Abdul Latif Vera Julia
7	P2-01B-07	Odontogenic Keratocyst Serial Cases of Three Patients	Ditha Noviantika, Lilies Dwi Sulistyani, Wenny Yulvie
8	P2-01B-08	Fibrous Dysplasia in The Mandible Dextra A Case Report	Rima Dini Januarti, Iwan Tofani, Eky Nasuri
9	P2-01B-09	Hemangioma on Maxillary Anterior A Case Report in Old Patient	Arian Reza Marwan Iwan Tofani Retnowati Gondo Sudiro
10	P2-01B-11	Surgical Management of Monostotic Fibrous Dysplasia A Case Report	Irfan, Abdul Latif, Retnowati Gondo Sudiro
11	P2-01B-12	Surgical Management of Temporomandibular Joint Ankylosis with Interpositional Arthroplasty Technique (Case Report)	Ricky Sanjaya Iwan Tofani Eky Nasuri
12	P2-01B-13	Management of Dentigerous Cyst with Maxillary Sinus Involvement A Case Report	Muhammad Aryaditha Yunial Vera Julia Retnowati Gondo Sudiro
13	P2-01B-13	Management of Denture-Induced Fibrous Inflammatory Hyperplasia in a Patient with Multiple Systemic Diseases	Arbi Wijaya Abdul Latif Retnowati Gondo Sudiro

POSTER PRESENTATION
Screen 2

DAY 2
Friday. 11th October 2019
13.00-14.30

No	No. Poster	Paper Title	Author
1	P2-02B-02	Surgical Procedure of Multiple Molar Impacted Teeth in Patient with a Congenital Adrenal Hyperplasia A Case Report	Putu Gede Putra Dananjaya Kawisana Abdul Latif Wenny Yulvie
2	P2-02B-03	Effect of Concentration of Clove Leaf Extract Gel on Macrophage Cells in Incision Gingiva Marmot	Hendri Poernomo Mochammad Taha Ma'ruf
3	P2-02B-04	Effectiveness of Binahong Leaf Extract Gel on Fibroblast Cell Counts in Aloxan-Induced Mice Incision Healing	Mochammad Taha Ma'ruf Putu Sulistiawati Dewi
4	P2-02B-05	Inhibition Test of Rhizome Bangle Extract Against Staphylococcus aureus Bacteria Growth In Vitro	Putu Sulistiawati Dewi Setiawan
5	P2-02B-06	Sialendoscopy, a New Methode in Evaluation and Management of Salivary Gland Obstruction Disease	Muslita R Wahyuni Benny S Latief
6	P2-02B-07	The Use of Koate-DVI in Hemophilia A Patient Undergoing Surgical Removal of Impacted Teeth A Case Report	Wyndi Novianti Kurnianto Lilies Dwi Sulistyani Eky Nasuri
7	P2-02B-08	Cyst and Ameloblastoma in the Histopathological of Mandibular Lesion A Case Report	Muskab Iwan Tofani Retnowati Gondo Sudiro
8	P2-02B-09	Lipoblastoma on the Tongue A Rare Case Report	Hendro A Sumjaya, Arfan Badeges, Etty Soenarti, Abdul Latif
9	P2-02B-10	Surgical Management of Mesiodens Based on Characteristic and Complication - a Systematic Review	Bayu Rahardian, Vera Julia, Lilies Dwi Sulistiani
10	P2-02B-11	Versatile Bone Grafts with Osteogenic Ions for Oral and Maxillofacial Surgery	Lilis Iskandar, Lucy Di-Silvio, Sanjukta Deb
11	P2-02B-12	Desmoplastic Type A Rare Variant of Ameloblastoma A Case Report	Febriadi Rosmanato, Iwan Tofani, Wenny Yulvie
12	P2-02B-13	Fasciitis Necroticans in an Obese Woman Case Report	Fitriana, Evy Eida Vitria, Arfan Badeges
13	P2-02B-14	The Potency of Red Algae Extract Gracilaria verrucosa from Aceh's Coast as Antibacterial Against Streptococcus mutans	S Chismirina R Andayani S Sungkar FY Yolanda
14	P2-02B-15	Indirect Pulp Capping in Immature Tooth Using Mineral Trioxide Aggregate (MTA)	Jessica Anggono Eva Fauziah

Unilateral TMJ Prosthesis after Segmental Mandible Resection and Disarticulation: A Case Series

Rumartha Putri Swari, Evy Eida Vitria[1], Wenny Yulvie [2]

[1]Departement of Oral and Maxillofacial Surgery, Faculty of Dentistry, Universitas Indonesia, Jakarta, Indonesia

[2]Department of Oral and Maxillofacial Surgery, RSUPN Cipto Mangunkusumo, Jakarta, Indonesia

***Corresponding author:**

Evy Eida Vitria
Department of Oral and Maxillofacial Surgery - Faculty of Dentistry Universitas Indonesia
Jl. Salemba Raya 4,Jakarta 10430,Indonesia
Email : evy_eida@yahoo.com,

ABSTRACT

Segmental mandible resection followed with treatment disarticulation of the temporomandibular joint (TMJ) is required for management of invasive mandible tumor. The used of prosthetic components were designed to restore major defects in the mandibular continuity. The several advantages for using the TMJ prosthesis are the reduction of surgical time and immediate function. In this case series there are two patients with a unilateral facial asymmetric et causa ameloblastoma. These two patients had been treated with segmental mandible resection and unilateral TMJ disarticulation replaced with TMJ prosthesis. This case series explained the management of segmental mandible resection and disarticulation and used of TMJ prosthesis on patients diagnosed with ameloblastoma. A well-managed procedure is very important to acquired maximal function of TMJ.

Key word: Temporomandibular joint, Disarticulation, Mandible Resection, Ameloblastoma

INTRODUCTION

Definition of ameloblastoma from WHO 1992 “a benign but locally invasive polymorphic neoplasm consisting of proliferating odontogenic epithelium, which usually has a follicular or plexiform pattern, lying in a fibrous stroma”. Ameloblastoma in the early stage hard to diagnosed because the absent of early symptoms. The swelling is painless and slow-growing. Melisch and coworkers found that beside swelling, patients also complain of pain, draining sinuses, and ulcerations. There are several sequele include mobile teeth, loosening dentures, malocclusion, and nasal obstruction. Prevalence of ameloblastoma in mandible four times compared to the maxilla [1]

Ameloblastomas include in a group of heterogenous tumours clinically and histologically. Ameloblastomas can be divided into three groups, unicystic, solid, and peripheral. Cystic and solid

ameloblastomas are intraosseous tumours and very similar, they have high recurrence rates. Intraosseous ameloblastomas and peripheral extraosseous ameloblastomas are histologically identical to but peripheral extraosseous ameloblastomas respond well to local excision[6]. The size of ameloblastomas have a very wide range from small to very large sizes which can cause a facial asymmetry to patient clinical appearance. The facial asymmetry can affect aesthetic problems and cause malfunction like malocclusion, mobile teeth, paresthesias and pathologic fractures. The swelling from tumor cause an expansion of cortical plates and also locally bone invasion. The tumour can present as a slowly progressive painless mass which may lead to aforesaid deficiencies[2]

Ameloblastoma treatment of choice may vary from radical curettage to bone resections, followed by reconstruction[7]. One of the treatment for ameloblatomas is surgery. Treatment for ameloblastoma are ranges from conservative approaches like curettage and enucleation to radical approaches bone resections. In some case radiotherapy can be an option but very rarely used as primary treatment. Some indication found in the literature for treatment option are electrocauterization, cryosurgery and sclerosant agents. Post-operative radiographic examination are important in the post-op follow up, because over 50% the recurrences happen in the first five years post operative[7].

The main factor to diagnose ameloblastoma correctly are tumor site and location, also radiographic examination. Definitive diagnosed can be achieved by using diagnostic modalities Lateral Oblique mandibular views ,Orthopantomographs, Computed Tomography (CT) scans and Magnetic Resonace Imaging (MRI). Radiographic imaging of the tumor appears as multilocular cyst like lesion of the jaw with a classical soap bubble appearance. The lesion sometimes appears with unilocular appearence[2].

CASE REPORT

Case One

A 26 year old young female patient reported to the outpatient Department Oral and Maxillofacial Surgery with a chief complaint of slowly increasing and painless swelling on the right side of the lower jaw since one year. The patient first visit to RS. Asrama Haji In 2012, patients complained of lumps in the right and lower back regions as large as pingpong ball and diagnosed with dentigerous cysts. Dentigerous cysts was enucleated and 46,47,48 tooth was extracted. In 2017, the patient feels more lumps in the lower right jaw and re-visit the Asrama Haji Hospital to do another check-up. The doctor recommend a jaw resection but patient reject because she was afraid. The last few months the patient report a maloclussion of tooth dan discomfort while chewing, later the patient came to RSCM. History of diabetes mellitus, hepatitis, heart abnormalities, allergies denied, lumps in other places did not exist. Patients deny family members with similar diseases

On extra oral examination showed an ill-defined swelling at the right two third part of the face measuring about 9.5x8x3cm extending from right mandible corpus to right buccal. The skin was smooth and has normal colour and normal temperature with no secondary changes to be found. It was non-tender and hard to the palpating fingers. The regional lymph node non palpable.

An intraoral examination showed an ill-defined solitary swelling in the right lower posterior buccal vestibule extending anterior-posteriorly from 44 to 48 extended to retromolar region measuring about 8x7x3 cm with smooth surface skin and mucosa overlying was stretched and similar to adjacent mucosal colour. It was non-tender and hard in consistency with buccal and lingual cortical plate expansion. The patient was subjected to radiographic and routine haematological examination. The haematological findings were not significant.

Figure 1. Extra oral examination of the patient, revealing a diffuse swelling over the right side of the face.

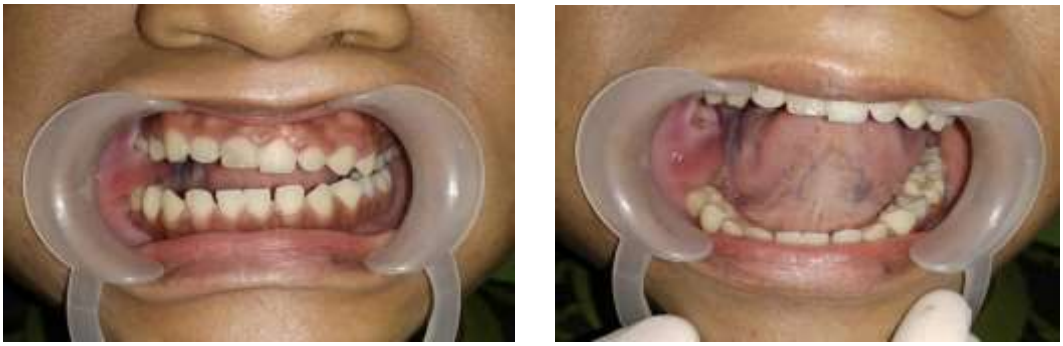


Figure 2. Intra oral examination revealing a diffuse swelling from tooth 44 to retromolar region.

Radiographic Finding

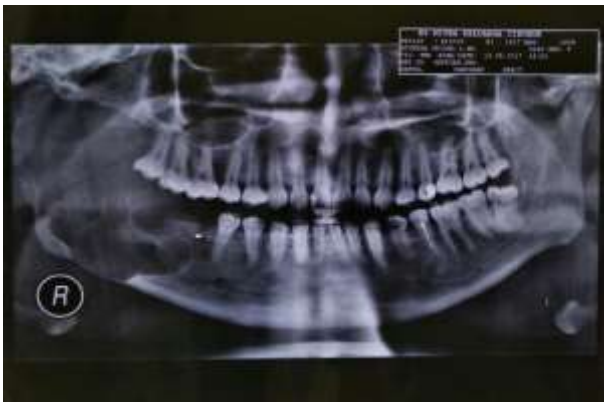


Figure 3. Panoramic radiographic showing a radioluscent imaging with well-defined border from distal 44 to condyle dextra

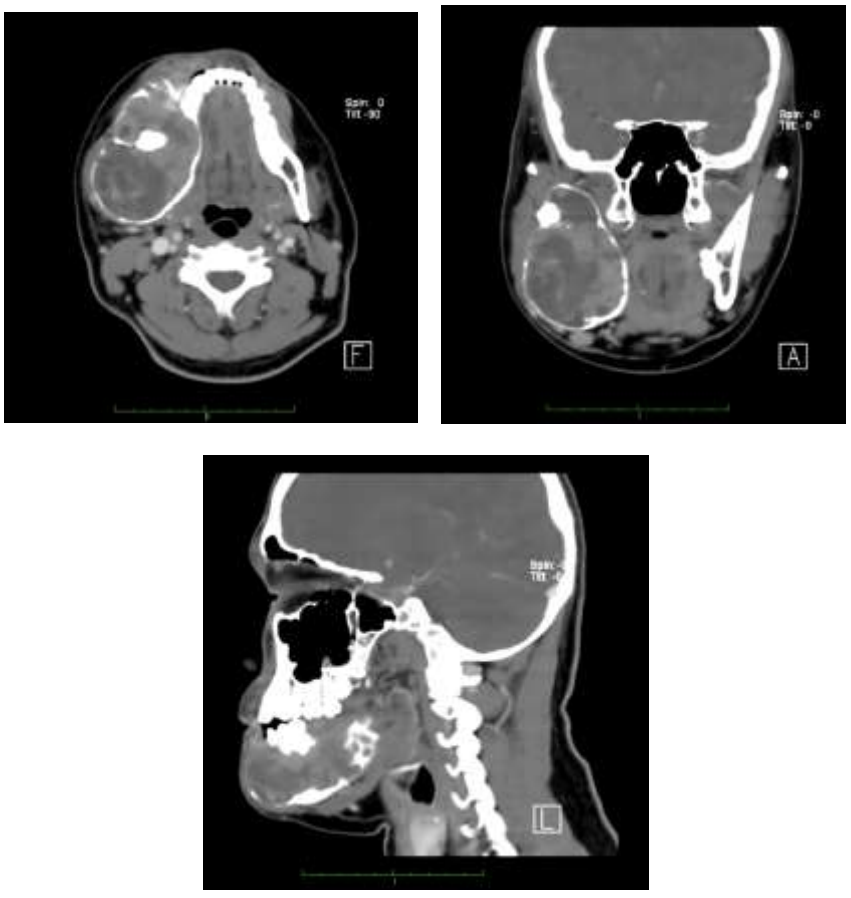


Figure 4. CT Scan revealed a very large well-defined radiolucent expansile lesion in the right body and ramus of the mandible with multilocular appearance causing expansion of the body and ramus.

Histopathologic Finding 27/9/2018

The biopsy specimen revealed islands cystic odontogenic tumor mass with eosinophilic material, arranged in follicular and plexiform patterns. Tumor cells are cuboidal to columnar composed of palisading, hyperchromatic. Stelate reticulum cells appeared on histopathological examination. These findings suggestive of follicular and plexiform ameloblastoma

CASE TWO

A 18 year old male patient reported to our department with painless, progressive swelling of lower right side of the jaw since nine months. Patient with history of Extra orally, swelling was seen in right lower one third of face extending from buccal dextra to corpus of mandible dextra. History of diabetes mellitus, hepatitis, heart abnormalities, allergies denied, lumps in other places did not exist. Patients deny family members with similar diseases.

Extra oral examination showed an ill-defined mass on the right lower third of the face about 8x8x4cm extending from right mandible corpus to right buccal. The skin over the swelling was smooth and the skin was normal colour with normal temperature on the surface of the mass. No secondary changes to be found. There are no report of pain on palpation. The regional lymph node non palpable. Intraoral examination revealed a swelling, posterior to 44 obliterating the buccal and lingual vestibule. Panoramic and occlusal radiographs showed multilocular lesion crossing midline, causing buccal cortical plate expansion. Histopathological examination was suggestive of Desmoplastic Ameloblastoma

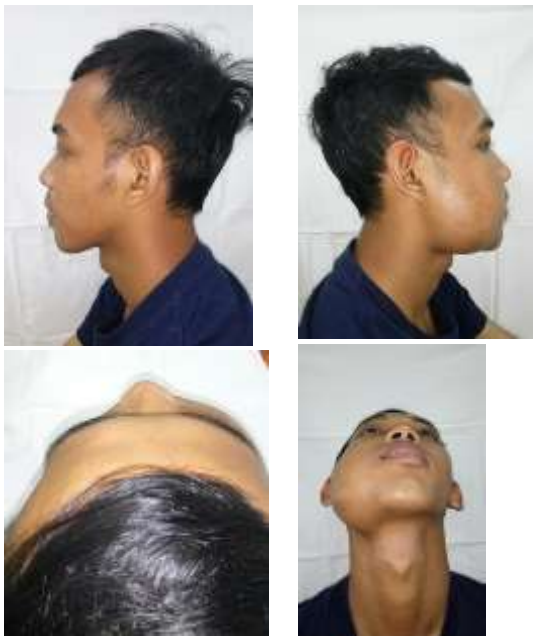


Figure 5. Extra oral examination of the patient, revealing a diffuse swelling over the right side of the face.

Figure 6. Intra oral examination revealing a diffuse swelling from tooth 44 to retromolar region.

Radiographic Finding

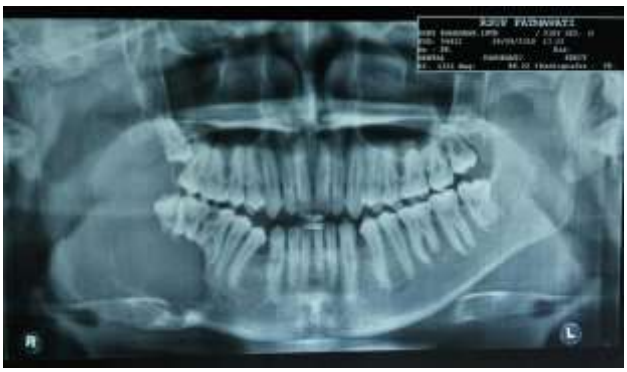


Figure 7. Panoramic radiographic showing a radioluscent imaging with well-defined border from distal 44 to condyle dextra and periapical 46-48 involvement.

TREATMENT

Ameloblastomas treatment of choice including curettage and marsupialitation, enucleation and radical surgery includes resection followed with or without continuity bone defect. For solid-multicystic and unicystic ameloblastoma of the mandible, treatment of choice was a resection of the jaw and should be approximately 1.5–2 cm marginal clearence, in order to ensure that all the 'microcysts' and 'daughter cysts' are removed. In our case also marginal clearance of 2 cm was achieved.

The patient was under general anesthesia with nasoendotracheal intubation. Patient was aseptic and antiseptic also sterile draped according to the standard surgical protocol. 2% lidocaine with epinephrine was injected with infiltration technic at the surgical site. Arch bar was performed at maxilla and mandible to achieve a stable occlusion. A sub mandibular incision was done and the size was depend on the size of the mass. The surgeon did a layered dissection to identificate the tumor mass. The inscision also done from intra oral site and reflection was done to expose the lesion. From the size of the ameloblastoma the mandible resection done with disarticulation. All the margins of the bone were smoothened with large fresser bur. Resected mass tumor was preserved in formalin for histopathologic examination. The reconstruction was done using MMF and reconstruction plate to secure the occlusion. A minimum of 3 screws were placed both on the proximal and distal segment. Irrigation was done with

sterile saline. The suture was done using vycril 3-0 for muscle and oral mucosa. Suture 5-0 polypropylene was used for skin closure. Pressure dressing was applied to the patients.

DISCUSSION

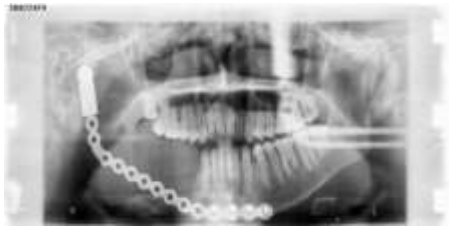
Treatment of mandible resection include an osteotomy of ramus to the sigmoid notch will provide adequate tumor margins and adequate bone will be preserved to provide fixation for the reconstruction in that case when the condyle can be preserved we must preserved the condyle. To apply fixation screw the condylar neck should be preserved and used to fixated the screw. The use of a reconstruction plate to provide flap fixation has several advantages over the use of multiple miniplates. In many cases the reconstruction plate can be adapted to the mandible prior to the mandibular resection. The bone flap can then be directly adapted to the contours of the bar and fixed with positioning screws. The size and location of tumor can makes hard to intraoperative adaptation of the plate, a 3-D model can be used to manage design of reconstruction plate. The plate can then be adapted to the ideal contour preoperatively, and the plate then applied after ameloblastoma resection[2].

The reconstruction of TMJ by using of alloplastic materials have been used successfully for many years. The report of success rate for total TMJ reconstruction using alloplastic TMJ replacement devices has been reported to be 84–91%. There are several report of complications related to total alloplastic TMJ reconstruction. The complication of intraoperative can include: injury to adjacent anatomical structures, such as blood vessels, nerves, ear canal, and salivary glands; and also poor adaptation of the device components to the healthy bone resulting in micromotion and can cause an early failure of alloplastic TMJ reconstruction. Another complication can happen during postoperative process include infection on operation site, haematoma, heterotopic bone deposition, salivary fistula, foreign body and/or hypersensitivity reaction to the alloplastic materials, the presence of malocclusion, failure of implant, and also pain. The purpose of any alloplastic TMJ replacement is the restoration of function and also the reduction of secondary symptom which can cause pain[1].

Trauma to the facial nerve branches is the most common causes for the complication resulting from neuropraxia caused by excessive pressure on the nerve from retraction and the presence haematoma. Axonesis can result from severance of the nerve or too aggressive use of electrocautery. The incidence of facial nerve problems increases with the number of prior operations and with the complexity of the pathology being addressed[1]. Limitation of mouth opening can occurs due to the trauma of mastication muscle.

Case One

Case Two



CONCLUSION

Ameloblatomas are benign invasive tumor which need to examine thoroughly from anamnesa , physically examination, and radiographic examination. Resection and disarticulation performed and follow up after 1 months after surgery. There are no pain symptom and discomfort.

REFERENCE

1. . Laskin DM. Oral and Maxillofacial Surgery, Vol. 2CV Mosby; 1999.
2. Thawley SE, Panje WR, Batsakis JG, Lindberg RD. Comprehensive Management of Head and Neck Tumors, Vol. 2 WB Saunders; 1987.
3. Gardner DG. Some current concepts on the pathology of ameloblastomas. Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 1996;82:660–669.
4. Pogrel MA, Montes DM. Is there a role for enucleation in the management of ameloblastoma. Int J Oral Maxillofac Surg. 2009;38:807–812.

5. Hammarfjord et al. Surgical treatment of recurring ameloblastoma, are there Options. British Journal of Oral and Maxillofacial Surgery 51 (2013) 762–766

6. G.B. Giraddi et al. Ameloblastoma: A retrospective analysis of 31 cases. Journal of Oral Biology and Craniofacial Research 7 (2017) 206–211

7. Regezi JA, Sciubba J. Odontogenic tumours. Oral pathology: clinical-pathologic correlations. Philadelphia:WB Saunders Company; 1989:337-348.
8. Machon, et al. Total alloplastic temporomandibular joint replacement: the Czech-Slovak initial experience. Int. J. Oral Maxillofac. Surg. 2012; 41: 514–517
9. Hupp JR, Ellis E, Tucker MR. Conteporary Oral and Maxillofacial Surgery.