Letter to the Editor

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To The Editor

I read with interest the recent article by Hari Ram et al. [1] entitled, efficacy of iliac crest versus medpor in orbital floor reconstruction. This is the excellent comparison of autogenous bone graft with allogenic graft in consideration with reconstruction of orbital floor and I congratulate the author for this wonderful job.

According to author indication for surgical intervention for orbital floor fractures include entrapment of orbital tissues, large orbital defect (greater than 50% of the orbital floor or more than 8 mm), or orbital floor defects with involvement of other zygomaticofrontal complex fractures. According to Rowe and William [2] floor defect larger than 1.5 cm needs surgical exploration.

Author had very well mentioned about orbital floor fracture complications like enophthalmos, limitation of orbital movements, diplopia, anesthesia or paresthesia of infraorbital nerve. Herniations of orbital content and unacceptable esthetic outcome are other complication of orbital floor fracture [3]. For both groups author used CT scans for radiographic confirmation. CT is recognized to be the best imaging technique to evaluate orbital floor fractures [4].

The four prerequisites for successful repair of fractures have been well mentioned: a thorough understanding of the regional anatomy; an accurate diagnosis; unimpeded exposure; and in some cases, rigid fixation of the fracture.

Implant material used for reconstruction of orbital floor should be biocompatible, noncarcinogenic, and easy to place in position and free of any potential for disease transmission [5]. The materials used by authors totally agreed these criteria. The autogenous iliac bone was compared with medpor (porous polyethylene) in ten patients each and both the groups showed satisfactory results, but the author considered medpor better because of no donor site morbidity, biocompatibility. Medpor is well tolerated by surrounding tissue, and its porous structure is rapidly infiltrative by host tissue and because of its flexibility it can be easily adapted to recipient site.

But author did not mention about the cost factor. Medpor is costly material and in rural setups like ours, patients are not able to afford these materials. Also autogenous bone grafts have osteo-conductive and osteo-inductive properties [6]. So autogenous bone grafts should also be considered equally good option for orbital floor reconstruction.

Author has used iliac crest for orbital floor reconstruction which is no doubt a very good autogenous bone graft, another option among autogenous bone graft is from mandibular symphysis region.

The mandibular symphysis graft is more accessible and easy to harvest in comparison to iliac crest, contour of the bone graft confirm to the orbital floor readily. Graft measuring 2 by 4 cm can be harvested from the symphysis and graft of this dimension would find application in the repair of majority of orbital floor defects [7]. Graft can be harvested with low morbidity and has very less resorption rate, as bone obtained from this region is cortical bone.

This is a letter to the editor in response to the article. Ram H, Singh RK, Mohammad S, Gupta AK (2010) Efficacy of iliac crest versus medpor in orbital floor reconstruction. J Maxillofac Oral Surg 9(2):134–141.

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This source is, however, often overlooked when an autogenous bone graft is needed for orbital floor reconstruction. The maxillofacial surgeon should therefore consider this readily available source of bone while reconstructing the orbital floor.

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