Letter to the Editor

Reply to: "The ENT's role in sinus lift management doesn't need misleading messages"

Replica a: "Il ruolo dello Specialista ORL nella gestione del grande rialzo sinusale non necessita di messaggi fuorvianti"

G. FELISATI[1], R. BORLONI[2], M. CHIAPASCO[3], P. LOZZA[1], P. CASENTINI[3], C. PIPOLO[1]

[1] Otorhinolaryngology Unit, Head and Neck Department, San Paolo Hospital, University of Milan; [2] Oral and Maxillofacial Surgery Unit, Istituto Stomatologico Italiano, Milan; [3] Oral Surgery Unit, Head and Neck Department, San Paolo Hospital, University of Milan, Italy

Acta Otorhinolaryngol Ital 2013;33:47-48

Dear Editor,

Two years ago we published an article in *Acta Otorhinolaryngologica Italica* entitled "*Maxillary sinus elevation in conjunction with transnasal endoscopic treatment of rhino-sinusal pathoses: preliminary results on 10 consecutively treated patients*" by G. Felisati et al. [1].

Two years later, Dr. Mario Mantovani published a letter to the editor in the same journal [2] with some negative comments on our publication.

Dr. Mantovani widely cited a previous publication published in 2008 [3] of which we are well aware, since the first author of the commented paper was one of the authors of this last manuscript.

In the 2008 paper, the authors stated that: "The potentially reversible otorhinolaryngological contraindications to sinus lift surgery need to be corrected by means of conservative medical therapy or functional endoscopic sinus surgery – FESS – (the current gold standard for many naso-sinusal conditions amenable to surgery) to restore physiological maxillary sinus clearance and ventilation, after which it is possible to perform the sinus lift procedure to begin oral rehabilitation."

Our proposal, published for the first time in 2010 and now opposed by Mantovani, was exactly the same as that proposed by Pignataro, Mantovani et al. in 2008, and also in previous publications by Mantovani.

The only difference is that, according to our approach and in selected cases, reversible contraindications to sinus lift requiring FESS for resolution can be treated in a single surgical session (FESS+sinus floor elevation (SFE)). It must be stressed, as we already have, that the combination of two different operations must be carefully planned and applied only in specific cases, by experienced surgeons.

In the first part of the letter, Dr. Mantovani, in the absence of any significant data, states that with our publication we may promote "*diffusion of misleading messages*". We believe that this phrase does not merit specific comments except for a fundamental one, namely that research brings new contributions over time, and that today we have the data to support our approach.

In the same letter to the editor, Dr. Mantovani stated that: "any surgical manoeuver apt to compromise the delicate homeostasis of the nose and the maxillary sinus must be formally contraindicated in conjunction with the sinus lift procedure".

The results reported in our publication showed that our surgical approach, performed on 10 consecutive patients, was not associated with any complications following sinus floor elevation in conjunction with FESS, similar to another 15 cases treated by us since then.

Thus, our comments to Dr. Mantovani's criticism consist in the following:

1. The clinical results appear to demonstrate that our combined and simultaneous approach (FESS+sinus lift) indeed does not compromise homeostasis of the maxillary sinus, provided that the sinus is well ventilated thanks to the FESS, which creates an efficient middle antrostomy.
2. In the second part of the letter, Dr. Mantovani's comments are directed towards the necessity or not of FESS in association with sinus floor elevation. He clearly defines *two points* that, in his opinion, demonstrate a structural weakness in our paper. *Firstly,* he underlined that "only three of the 10 patients treated according this combined protocol reported recurrent minor rhinosinusitis. We can then argue that the other seven were free of rhino-sinusitis: why then were they operated on?". *Secondly,* he reported that: "Four patients presented with a large maxillary sinus cyst: why did they undergo an endoscopic transnasal approach … when it was possible to empty the cyst by a simple and well known trans-oral non-invasive manoeuver?"

The two points are very important not only *per se*, but in more general terms, to understand what is really needed in patients who must undergo SFE.

Considering the first point of the letter, Dr. Mantovani stated that anatomical alterations need a history of sinusitis to constitute a true contraindication for SFE (which requires FESS prior to SFE). This statement is reminiscent of the data reported by Timmenga e al (1997) [4] which is the only clinical report presently available in the literature (to our knowledge) on the risk of SFE failure. On the other hand, in other reports [5,] Mantovani appears to sustain that all the reversible contraindications to SFE (such as septal deviation or concha bullosa) need to be corrected prior to SFE without taking into account a history of sinusitis.

We would like to present our point of view.

First of all, it would be strange to base surgical indications on the basis of anamnesis when it is well known that diagnosis of sinusitis made by patients or by a general practitioner is highly unreliable [6]. In trying to answer to the question "*what is right*" we can say that our combined approach makes SFE safer, especially when a large SFE is programmed to allow the insertion of multiple dental implants. Secondly, the combined approach that we propose solves, at the same time, rhino-sinusal problems that were only minor in the 10 cases reported in the article published in 2010[1], but which were also relevant in the consecutive 15 new cases carried out to date. For these reasons, we continue to perform, *in selected cases*, a combined approach.

Considering the second point, Dr. Mantovani states that maxillary cysts do not require FESS. In the 2008 paper [3], therefore, only small cysts were not considered as a contraindication to SFE, while large ones should be treated prior to SFE (or in our hands simultaneously).

We agree with the proposal to puncture the cyst during SFE for cysts of small or medium size, but we are not sure that this technique is "well known", and we think that it cannot be considered validated for large cysts that can still create an occlusion of the ostium (immediate or delayed).

In conclusion, we believe scientific debate to be beneficial, but all should be open to new developments and be confident in their statements only when relying on reliable data.

References

1. Felisati G, Borloni R, Chiapasco M, et al. *Maxillary sinus elevation in conjunction with transnasal endoscopic treatment of rhino-sinusal pathoses: preliminary results on 10 consecutively treated patients.* Acta Otorhinolaryngol Ital 2010;30:289-93.
2. Mantovani M. *The ENT's role in sinus lift management doesn't need misleading messages.* Acta Otorhinolaryngol Ital. 2012;32:404.
3. Pignataro L, Mantovani M, Torretta S, et al. *ENT assessment in the integrated management of candidate for (maxillary) sinus lift.* Acta Otorhinolaryngol Ital 2008;28:110-9.
4. Timmenga NM, Raghoebar GM, Boering G, et al. *Maxillary sinus function after sinus lifts for the insertion of dental implants.* J Oral Maxillofac Surg 1997;55:936-9, discussion 940.
5. Mantovani M. *Otorhinolaryngological contraindications in augmentation of the maxillary sinus.* In: Testori T, et al., editors. *Maxillary Sinus Surgery and alternatives in treatment.* London: Quintessence Publishing Co. Ltd.: 2009. p. 23-33.
6. Jones NS. *Sinus headaches: avoiding over- and mis-diagnosis.* Expert Rev Neurother 2009;9:439-44.

Received: January 7, 2013 - Accepted: January 22, 2013

Address for correspondence: Giovanni Felisati, Dipartimento Testa e Collo, Ospedale San Paolo, Università di Milano, via di Rudinì 8, 20142 Milano. Fax +39 02 50323166. E-mail: giovanni.felisati@gmail.com