Letters to the Editor

Survival of a subperiosteal tantalum mesh from 1955 to 2004

Since 1999 I have used an implant system, based on stereolithographic models and a custom-made titanium mesh that is placed subperiosteally with transmucosal posts to support a mandibular denture. This has proved successful in patients for whom conventional implants have been unsuccessful or technically difficult. I have presented some of these cases in Dallas in 2002 (TX, USA, 17th annual meeting of the Academy of Osseointegration) and in Boston in 2003 (18th annual meeting of the Academy of Osseointegration).

In the course of recent correspondence with Professor Leonard I. Linkow, clinical professor in the Department of Implantology, NY University, whom I had asked to examine my research work, I was informed of a subperiosteal implant operation done in Rome in 1955 by Professor Luigi Marziani, director of the Eastmann University.1

In 1955 in a 6-h single-stage operation under general anaesthesia, Professor Marziani placed full arch tantalum mesh subperiosteal implants in the maxilla and mandible of a 29-year-old woman. Considerazioni sugli impianti sottoperiostali. Estratto degli Atti del Simposio Degli Implanti Alloplastici, 19–20 Marzo 1955, Clinica Od. Univ. di Pavia, Associazione Europea Odontostomatologica per gli Implanti. 2

In 1977 the maxillary mesh was removed because of the sudden onset of infection. The patient, now 79 years old and in good health, is still a client of the department.

I examined her on 7 May 2004. The mandibular mesh was still in place after almost 50 years. Although 60% of the mesh had been exposed by dehiscences, there was no evidence of inflammatory tissues in the gingival mucosa and the implant met the aesthethic and functional demands of the patient. The patient, now 79 years old and in good health, is still a client of the department.

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This case emphasises several points. First, there is often a precedent for what seems to be a new idea or treatment, and it may be difficult to find despite extended searches of published work. Secondly, the principle of fibrointegration formulated by Linkow et al.3 seems to have been further confirmed by this case. Lastly, pioneering work may go unrecognised by the clinical community.

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References


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Re: Majumdar et al. The ‘Chesterfield stent’: An aid to the placement of midpalatal implants. BJOMS 2005; 43: 36–9

I read with great interest this description of a surgical stent to aid placement of orthodontic palatal implants.4 From my experiences of the Orthosystem, I strongly agree that careful planning in these cases greatly facilitates both surgical stages (insertion and explantation), and also the ease and effectiveness of the subsequent orthodontics. Various designs of stent have been described5,6 and the authors rightly point out that these have limitations. However, the illustrations in their paper do not support their concluding statement that their stent “ensures precise location and angulation of the implant and predictability of its placement.” In particular, the postoperative radiograph (Fig. 4) shows the implant at a much steeper inclination (close to 90° to the occlusal plane) than their proposed 60° position. I suggest that this error occurs for two reasons. Firstly, there does not seem to be a well-defined pro-