Conclusion: The primary reconstruction is an obligatory stage of surgical treatment as part of complex therapy of BMC. An individual choice of an appropriate plastic technique depending on tumor localization and dissemination, a wide spectrum of various plastic facilities provide favorable outcome from cosmetic, functional and oncological points of view.
A great variety of regional grafts guarantees complete and valid substitution of the buccal mucosa defects located at different sites. The application of free revascularized grafts is indicated for replacement of extensive lesions, the defects involving 2 epithelial layers or combined osteo-mucous lesions.

PD.61 Surgical excision of oral pre-cancer: long-term results from a randomised controlled screening trial

M. Pandey[1], G. Thomas[1], T. Somanathan[1], K. Ramdas[1], R. Sankaranarayanan[2]. [1]*Regional Canceer Centre, Medical College PO, Trivndrum, Kerala, India;* [2]*International Agency for Research on Cancer, Lyon, France*

Introduction: Oral cancer is the commonest cancer among males. Invasive oral cancers are preceded by precancerous lesions in a large majority of cases. The clinical management of oral precancerous lesions presents major challenges, in view of the field cancerisation effect due to long-term exposure to tobacco and alcohol habits
Materials and Methods: Subjects with oral precancer identified in a randomised controlled oral cancer screening trial underwent surgical excision. The detailed methodology is reported elsewhere [1]. The results of excision were analysed using Kaplan Meier method and were compared using long-rank test for known predictor variables. Both recurrence and new lesions were considered event for event free survival
Results: Of the 114 cases, 64 (51.6%) were located on buccal mucosa followed by 31 (25%) on commissure and 15 (12%) on tongue. The commonest clinical diagnosis was ulcerated leukoplakia in 64 (51.6%), 19 (15.3%) had verrucus leukoplakia. Dysplasia was found in 74(55.6%) cases of which it was moderate in 53(39.6%) and severe in 12(9.0%). A total of 25 subjects (20.2%) recurred while 14(11.3%) developed new lesions after a mean follow-up of 35 months (median 38). The event free survival was 54.8%. None of the variables studied found to have a significant effect on event free survival
Conclusion: Result of surgical excision at 5-year are good suggesting that surgical excision of oral leukoplakia could be the ideal treatment.

PD.62 Simultaneous mandibulotomy and marginal mandibulectomy – an outcome study

C.-C. Wang, S.-P. Hao. *Chang Gung Memorial Hospital, Taiwan*

Introduction: To evaluate the outcome of simultaneous mandibulotomy and marginal mandibulectomy for patients with oral cavity cancer.
Materials and Methods: The medical charts of 7 patients who underwent simultaneous mandibulotomy and marginal mandibulectomy for oral cavity cancer between 1994 and 2004 in Chang Gung Memorial Hospital were retrospectively reviewed. These 7 patients had no prior radiation therapy and no clinical or radiographic evidence of mandible bone invasion.
Results: Seven patients, aged from 42 to 62 years, were followed up in the clinics from 4.5 to 39 months (mean follow-up period, 17.6 months). One patient died with neck recurrence and another one patient died with distant metastasis. The local control rated was 100% and the 2-year actually survival rate was 43%. Five patients (71%) developed mandible osteoradionecrosis. Among them, two patients underwent radical sequestrectomy and were reconstructed with fibular osteocutaneous free flap or soft tissue flap and 3 had the mandible fixation mini-plate removed, limited sequestrectomy of mandible or conservative antibiotics treatment individually.
Conclusion: Simultaneous mandibulotomy and marginal mandibulectomy for oral cavity cancer, though technically feasible, warrant an unacceptably high complication rate. Based on our experience, simultaneous mandibulectomy and marginal mandibulectomy should be avoided. A segmental mandibulectomy with free fibular flap is a reasonable option for patients with trismus and posteriorly located tumor.

PD.63 The surgical treatment of stage III mandibular osteoradionecrosis. Report of 6 cases

G. Faratzis, S. Stavrianos, C. Assimomitis, H. Apostolidis, G. Kokkalis, A.D. Rapidis. *Departments of Plastic and Maxillofacial Surgery, Greek Anticancer Institute, Saint Savvas Hospital, Athens, Greece*

Introduction: Treatment of oro-facial malignancies includes radiotherapy either as sole modality or as part of combined treatment with surgery and chemotherapy. Patients receiving radiotherapy are at risk of developing osteoradionecrosis of the bones in the treated area. Osteoradionecrosis is an extremely painful, debilitating disease that, according to its stage, can even compromise the patient's life. The best treatment is its prevention to occur but when present in an advanced stage the combination of surgical and medical treatment produce satisfactory results.
Materials and Methods: During the last 6 years a series of 6 consecutive patients with stage III osteoradionecrosis of the mandible were treated in our Department. There were 4 male and 2 female patients that developed osteoradionecrosis of the mandible between two and four years after radiotherapy. Four of the patients had brachytherapy after completion of external beam irradiation whereas the other two had only conventional radiotherapy. None of the patients had surgery as part of their treatment. Dental extractions were the initiating factor for the development of osteoradionecrosis. There was no edentulous patient. All 6 patients had previous hyperbaric oxygen therapy. All patients were treated with free tissue transfer combined with varius myocutaneous flaps. The types of flaps used included 4 free fibulas, 4 radial forearm free flaps (3 as osteo-dermo-cutaneous and 1 dermocutaneous free flap), 3 pectoralis major and 1 deltopectoral flap.
Results: All patients are alive and free of both the neoplastic disease and osteoradionecrosis. In all patients various post-operative complications occurred and required for treatment a number of surgical interventions. Functional and aesthetic results are acceptable.
Conclusion: Although mandibular osteoradionecrosis is rather uncommon, compared to the large number of patients that receive radiotherapy for cancer of the head and neck area, treatment for the advanced stage disease is difficult and complicated. It is therefore advised to prevent disease occurrence with the use of appropriate dental treatment to patients that will be subjected to radiotherapy.