Letter to the Editor

The ENT's role in sinus lift management doesn't need misleading messages

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

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Dear Editor,

I read with great attention the article by G. Felisati et al. [1], *Maxillary sinus elevation in conjunction with transnasal endoscopic treatment of rhino-sinusal pathoses: preliminary results on 10 consecutively treated patients*.

The article supports, quite surprisingly, the possibility of combining functional endoscopic sinus surgery (to treat local contraindications to sinus augmentation) simultaneously with the sinus lift procedure itself in order to avoid a double procedure. As clearly reported in the article, "ENT assessment in the integrated management of candidate for (maxillary) sinus lift" [2], the first ENT publication dealing systematically with this emerging interdisciplinary topic according to the Messerklinger philosophy, in order to avoid postoperative complications of the sinus lift procedure, *per se* apt to jeopardize the delicate homeostasis of the maxillary sinus, "the concomitant presence of systemic, naso-sinusal or maxillary sinus diseases" representing potentially reversible contraindications, must be first detected (the first preventive-diagnostic step), and then corrected (the second preventive-therapeutic) "in order to restore the physiological drainage and ventilation of the maxillary sinus". Only after the verified reestablishment of these last conditions can the patient be submitted to the sinus lift operation.

According this protocol accepted worldwide, developed by the Italian ENT School of Milan, any surgical manoeuvre apt to compromise the delicate homeostasis of the nose and the maxillary sinus must be formally contraindicated in conjunction with the sinus lift procedure, because responsible of possible iatrogenic complications and failure of the implantologic rehabilitation.

As reported in the same article the "anatomic alterations that impair physiological maxillary drainage and are responsible for sinus dysventilation" must be corrected before sinus lift "in case of associated sinus diseases".

If we consider in detail Felisati et al.'s article [1], 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? Four patients presented with large maxillary sinus cyst: why did they undergo an endoscopic transnasal approach (creating ostium enlargement with the unavoidable perturbation of the delicate homeostasis of the naso-antral physiology and endosinusal NO content) when it was possible to empty the cyst by a simple and well known trans-oral non-invasive manoeuvre consisting in the evacuation of the cystic fluid, puncturing its base through the vestibular window created by the implantologist for the sinus lift procedure?

The cooperation of the ENT and implantologist [3] is a very new and delicate issue showing a promising expansion and increasing the specific role of our speciality.

We must carefully avoid the diffusion of misleading messages apt to jeopardize the safety of the methodologic approach already mentioned that, at present, appears to be universally well accepted and fully validated.

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 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.

3 Mantovani M. *Implicazioni otorinolaringoiatriche nell'elevazione del seno mascellare*. In: Testori T, Weinstein R, Wallace S, editors. *La chirurgia del seno mascellare*. Viterbo, Italy: ACME Sas; 2005. p.41-52

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