


Letter to the Editor

Reply to “A modified sagittal split osteotomy: description of technique”

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Dear Editor,

We would like to thank you for your interest in our paper [1] and for bringing to our attention such important academic and scientific topics of discussion. In the first place, we want to clarify that at the moment the article was submitted, we did not acknowledge the article by Grimaud *et al.* “Vertical ramus elongation and mandibular advancement by endobuccal approach: Presentation of a new osteotomy technique” [2], because when we performed our literature search in 2020 using PubMed and Medline databases, the following strategies were used: “osteotomy ramus AND orthognathic surgery AND vertical ramus” and “MeSH Term (((“orthognathic surgery”[MeSH Terms]) AND (condyle, mandibular[MeSH Terms])) AND (osteotomy, sagittal split ramus[MeSH Terms]”, and said the article did not appear within the results. However, we now recognize that the article by Girmaud *et al.*, and the article by T. Loncle “Modified technique used for sagittal splitting of the mandible” [3], present very similar techniques with quite the same clinical goals ad results in the treatment of Class II patients with severe loss of posterior facial height; a slight difference could be the fact that the presented cases for this technique were both done using the Wolfords protocol described in 2015 for inactive condylar resorption in Class II patients [4], that carries a simultaneous bilateral meniscopexy, since the loss of posterior facial height was attributed to the past condylar resorption. In addition, it needs to be stated that any kind of mandibular osteotomy design that included the gonial area in the distal fragment, could bear the same results such as the L-inverted osteotomy, the Epker-modified Wolford osteotomy and the Caldwell-Letterman technique, as you stated [5–7]; only, they face a greater restriction in the amount of mandibular advancement that can be achieved.

We would also like to agree with you, and as we said in the articles conclusion, that long-term follow-ups and bigger patient samples are required to establish the stability and relapse rate of these techniques.

On the other hand, the rigid fixation of our choice was three bicortical screws in an L-inverted distribution, these screws were placed using a transbuccal device with a trocar and a cheek retractor, thus being an accepted approach to provide safe and excellent skeletal stability [8,9], and at the same time we lower costs for the patient in osteosynthesis material; besides, the scar left by the transbuccal device is minimum (less than 8 mm long) and we haven’t had any complaints about it from the patients since its imperceptible; however, the angled drilling device is an excellent option to avoid a scar.

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