Author’s response to reviews

Title: Quality of life and problems associated with obturators of patients with maxillectomies

Authors:

Marwa Ali (melameen@hotmail.com)
Nadia Khalifa (n.khalifa@hotmail.com)
Mohammed Alhajj (m.n.alhajj@hotmail.com)

Version: 1 Date: 12 Nov 2017

Author’s response to reviews:

Dear Editor,

On behalf of all authors, I am greatly thankful to you and your reviewers for assigning your valuable time reviewing our manuscript and I really appreciate your efforts as well as your constructive comments.

Kindly find the responses to the comments listed below. I confirm that all authors have approved these responses. The arising changes have been added to the manuscript.

Thank you in advance.

Responses to comments:

Reviewer #1: The authors of the current manuscript aimed to evaluate patients treated by maxillectomy and obturator prosthesis for reconstruction. In this survey, the authors evaluated the patients’ quality of life after integration of the obturator prosthesis. I would like to raise some queries:
1) I believe that reconstruction immediately after tumor resection remains a standard approach in tumor patients, which has been shown to be a European as well as a worldwide standard. (see Kansy et al.) This needs to be mentioned here.

With large resections of tumors it could be impossible for immediate surgical reconstructions. Instead, maxillofacial prosthesis might be the preferred solution for such cases (This has been discussed in the last paragraph in the “Discussion” section).

2) Restoration of form and function cannot be achieved by obturator prosthesis, since this restoration is not stable, as also presented in the current survey. The authors critically have to discuss the indications for prosthesis vs. reconstruction by free flaps.

This has been discussed in the last paragraph in the “Discussion” section.

3) The prosthesis does not simplify oncological follow ups, since infection and worse fits generate potential confounders and probably more biopsies, which can easily detected by CT scans also if reconstructed. I therefore disagree with this statement.

This has been discussed in the last paragraph in the “Discussion” section.

4) There are several studies with this concern. Especially in QoL and maxillectomy patients. If the authors would have a higher grade of evidence, they should state this, but not that there is a lack of evidence.

We have stated that there is a lack of information pertaining the use of subjective and objective methods together among maxillectomy patients who are wearing obturators. We subjectively evaluated functions such as mastication, swallowing, and speech along with aesthetics and psychological status in patients with maxillary obturators and we objectively assessed the retention and stability of obturators. We investigated the relationships between many variables and we, for the first time, translated and adapted the Arabic version of the Obturator Functioning Scale.

5) The results can be also interpreted as there is not a well suited soluted provided. This is more a point of view, but I believe that for a correct analysis reconstructed patients need to be integrated in this study for objective and valid analysis.
We have analyzed many variables including the responses of the subjects to the Obturator Functioning Scale, clinical examination of the subjects, association between the study variables, and the characteristics of the subjects and their influence on the quality of life.

Reviewer #2: Dear Author

The manuscript entitled "Quality of life and problems associated with obturators of patients with maxillectomies" presents an interesting research, which I propose for publication.

Minor revisions are needed:

* Page 7, line 14. Instead of 13,3% were widow and 3.3% were divorced, it should be written, according to Table 1, 13,3% were divorced and 3.3% were widow

Done…

* Page 8, line 29. Instead of only 6% . . . . , it should be written 26% of responders had received radiotherapy

Done…

* Page 14 (References)

Line 5 Keyf F. (full stop)

Line 13 Lauris JR. (full stop)

Line 19 IJDA 2002;2 (pages?)

Line 20 Warriach RA. (full stop)

Line 34 Khug GE. (full stop)
Reviewer #3: An extremely interesting article regarding quality of life and problems associated with obturators of patients with maxillectomies. It is well conducted and of big clinical significance; however, some changes are needed.

Abstract: Some sentences could be grammatically improved and others are confusing, leading to a poor understanding of the manuscript's main idea.

The “Abstract” section has been revised.

Methods: Was there a sample size calculation? If so, how did the authors do that?

All archival records at the prosthodontics department from 2010 to 2014 were reviewed to retrieve data of patients who had obturator construction. Thirty eight patients were identified and only 30 of them agreed to participate.

References: There are some problems regarding format.
Corrected according to the journal’s style.

Tables: The authors must add information on p-value, variables (e.g. years, months), and other important features. It is better not to use bold for significant p-values on tables.

More information have been added and the bold for significance has been removed.

Reviewer #4: Thank you for submitting this excellent and well-written paper on post-maxillectomy QoL with obturators

My only comments are that you make two additions to the Discussion:

Firstly, whilst the Aramany classification is an excellent tool for the prosthodontist, it does not concur with the commonly used ones by surgeons. You should discuss this point.

Whilst the Aramany classification system of maxillectomy defects has been widely used by prosthodontists, it is not the most commonly used by surgeons. This because Aramany classification system provides classification after healing has occurred and after the loss of any opportunity of immediate surgical reconstruction. On the other side, surgeons’ perspective of classification depends on the surgical resection. Hence, several maxillectomy classification systems have been proposed but, till now, no consensus has been reached. (This paragraph has been added to the “Discussion” section and the related references have been added to the manuscript)

Secondly, there is no doubt that an obturator has many advantages over surgical reconstruction but to say, as you do on page 12, line 10 -13 that the surgeon should try to keep the defect as small as possible, is not really valid in the management of malignant disease. However, here is an opportunity to briefly discuss the advantages of an obturator when compared with microvascular or local flap reconstruction within the context of QoL.

Although free microvascularized flaps or pedicled flaps can be used as surgical means to repair maxillofacial defects, these flaps might be not suitable for large resections or defects. Instead, maxillofacial prostheses can be used effectively to obturate these defects. Several advantages can be achieved with obturators such as: replacing teeth as well as soft and hard tissues, allowing
approximately normal speaking and swallowing for the patient. In addition, it prevent fluids leakage and communication between nasal and oral cavities. Moreover, it enhances the facial appearance as it provides support for the face tissues. Another benefit of the obturator is that it permits clear vision and may be early detection of tumor recurrence. (This paragraph has been added to the “Discussion” section and the related references have been added to the manuscript)