Lingual Vascular Canal: How Far or How Close is it?

C. S. Vane Swetah¹, Dr. Suresh V²

¹Graduate, Saveetha Dental College, Poonamalle High Road, Chennai, India
²Reader, Department of Prosthodontics, Saveetha Dental College, Chennai, India

Abstract: **Research Title:** Lingual vascular canal - How far or how close is it? **Research question:** What is the distance of the lingual vascular canal from the crestal bone, the labial bone and the deviations, if present, from the midline? **Aim:** To assess the variations in the dimensions from the crestal and the cortical bone to a lesser known lingual vascular canal in the anterior mandible region. **Objective:** To evaluate the distance of the lingual vascular canal from the crestal bone, the labial bone and the deviations from the midline for implant planning. **Materials and Methods:** Total sample of 55 CBCT scans were collected out of which 10 showed lingual vascular canal with anterior teeth missing and were subjected to radiological evaluation. The anatomical position of lingual vascular canal to the crestal bone and labial cortical bone along with deviations from the midline were assessed in the cross sectional view. The mean value of the results were obtained and tabulated. **Results:** The average distance from crestal bone was found to be 14.05 mm and the average distance from labial bone was found to be 5.7 mm. The average deviation from the midline was found to be 2 mm towards either the left or the right side.

**Keywords:** Lingual vascular canal, crestal bone, labial bone, midline deviation

1. Introduction

The anterior region of the mandible is one of the common regions subjected to surgical procedure. Due to it being a part of the aesthetic zone, care must be taken to given to deliver the most appropriate form of treatment. Dental implants are a new and fast upcoming mode of comprehensive treatment plan for rehabilitation for edentulous patient. A thorough assessment, which includes radiographic evaluation and systemic evaluation, is a compulsory prerequisite for treatment planning.

There are several radiographic methods used for treatment planning. However the use of Cone beam computed tomography is the most preferred and accurate till date [1]. The CBCT helps in visualising the anatomical regions on a three dimensional plane. It shows a detailed assessment of all the bony structures.

Despite having a high success rate, there are several possible complications such as haemorrhage, neural disturbances and Implant failures which can occurs due to placement of implant in resorbed arches [1].

One of the most common complications in the lower anterior region is injury to the lingual vascular canal [2]. Because of the presence of neural as well as vascular components, the implication of canal impingement is high. The vascular canal creeps much closer to the ridge upon resorption and therefore careful Implant length must be selected for a long lasting Implant.

Considering the importance of this region, the present study was conducted to assess the distance of crestal and labial bone from the lingual canal and its deviation from the midline.

2. Materials and Methods

55 CBCT scans were collected from Saveetha dental college in Chennai, India and a retrospective analysis was done. Permission for the collection scans was acquired from the department of Oral medicine and Radiology. Scans of patients with lower anterior teeth missing were selected for this study, which included recently extracted as well as completely edentulous patients.

The CBCT’s with lingual vascular canal clearly mapped were 10. The scans were analysed in GALAXIS Galileos implant software. The distances from the labial and crestal bone were assessed, followed by any deviation in the midline.

The mean value of the results were obtained and tabulated.

Inclusion Criteria:

1. Completely Edentulous or partially edentulous patients of Indian ethnicity between ages of 20 and 60 years.
2. Healthy and medically compromised patients were included.

Exclusion Criteria:

1. Patients with any history or trauma or mandibular pathologies
2. Patients of non-Indian ethnicity
3. CBCTs which appear distorted or blurred to due incorrect patient positioning.
Mendonca-Cardad and Givol assumed that the content in the vascular lingual canal is an anastomosis of the sublingual branch of left and right lingual arteries [4, 5, 6, 7, 8]. This implies that the size of the artery could be sufficient enough to provoke a haemorrhage-intraosseously or in connective tissue which will be hard to control. This view is in contrast to Goaz and white who stated that the canal were termination of the incisalbranch of the mandibular canal [9].

CBCT and CT scans are the gold standard for visualisation of the lingual canal as stated by Yoshida et al, who stated the difficulties of radiographic evaluation of the canal [10]. CT is important tool for visualising accurate anatomical structure and position, bone topography, osseous pathology associated with dental implantology. [11]. Another option for visualisation in the MPR of multiple aliases reformation. It provides an accurate visualisation of midline mandibular structures depicting the size and shape of the lingual vascular canal which correlates to the anatomic literature. [12, 13, 14]. The difference is due to the limited resolution capacity of the CT as compared to a MPR.

In several studies, the lingual canal was found in the midline. According to McDonnell et al., lingual foramen was present in 99% in midline of mandible [6]. In the study found by Jaju and Jaju, [2] the most common location found for this vascular canal was in midline of the mandible with 75%.

As per Jaju and Jaju [2], the mean distance of the canal measured from the inferior border of mandible was 0.56 mm. The mean distance in males was 0.64 mm while for females it was 0.45 mm. The longest canal distance was 16.9 mm while the shortest distance was 1.5 mm. The largest diameter of vessel noted was 1.6 mm while the smallest vessel diameter was 0.01 mm. The mean diameter of the vessel was 0.31 mm. The mean diameter for males and females was 0.36 mm. There was no significant correlation found between different age groups and sexes with respect to frequency, number, and size of the canal. Where as Gultekin et al, revealed a mean diameter of lingual canal as 0.8 mm±0.2 mm in the middle [15].

Cova et al., found that 0-5 canals were found in individual patients. [16] whereas Scaravilli et al., found that the 90.3% had at least one lingual vascular canal and 45.6% had multiple (up to ) canals [17].

There were no literature studies with the measurement of lingual and cortical bone distance for further evaluation or comparison.

Age related changes and osteoporotic factors can influence the canals position. The ossification around the canal can reduce which in turn can reduce visibility of canal during radiographic evaluation. Additionally, the structures are based on quality of the radiographs which will vary. With age based resorption, the lingual vascular canal can creep closer to the ridge which makes Implant length selection an important process to avoid complications.
The difference in results could be due to difference in machines, protocols and observer variability, which should be taken into account.

Further studies should focus more on clinical and radiological variations of the lingual vascular canal and their involve the in complications to provide a better standard of treatment.

5. Conclusion

With an increase in trend in the placement of dental implants, there is an increase in post operative complications as well. Damage to the lingual vascular canal is one such complication which can lead to haemorrhage and Implant failure. However, with the use of cone beam computed tomography and CT scans, we can visualise the jaw anatomy with great accuracy and thereby reducing any post operative complications which arises due to poor mandibular Anatomy and poor treatment planning.

References