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## **Utility of Decellularized Urinary Bladder Extracellular Matrix in Full Mucosalization of a Post-Oncologic Maxillectomy Defect**

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# **Utility of decellularised urinary bladder extracellular matrix in full mucosalisation of a post-oncological maxillectomy defect**

## **Abstract**

This report highlights the utility of MatriStem Surgical Matrix Thick UBM™ (rebranded as Gentrix® ACell, Inc), a decellularised urinary bladder extracellular matrix in the reconstruction of a post-oncological maxillectomy defect. In utilising this biological construct to serve as a biological dressing, our patient underwent complete mucosalisation of his surgical site without the development of an oroantral fistula and with adequate maxillary vestibule to allow for definitive oral rehabilitation with a removable partial denture.

**Keywords:** urinary bladder extracellular matrix, MatriStem, maxillary reconstruction

## **Introduction**

While the use of bioengineered skin and soft tissue substitutes has been well established in the reconstruction of cutaneous defects of the head and neck, their utility in oral mucosal reconstruction is not as well defined. Therefore, we describe the application of a decellularised porcine urinary bladder matrix in maxillary reconstruction.

## **Case report**

The patient was an 83-year-old man with a biopsy-proven diagnosis of squamous cell carcinoma of the right maxillary gingiva, which had been initially staged as cT2N0MO. He had never smoked, and had a past medical history significant for coronary artery disease, carotid

artery stenosis, hyperlipidaemia, and hypothyroidism. He was planned for primary tumour extirpation and personally elected for management of the primary site and against an elective neck dissection, and his reconstructive preference was for a prosthetic obturator. Following completion of his maxillectomy, a Brown Class 1d defect was created.<sup>1</sup> Due to the cancerous lesion being limited to the attached gingiva during the maxillectomy procedure, the integrity of the nasal mucosa was maintained as much as possible and a small area of laceration (Fig. 1) was noted with the advancement of an ipsilateral buccal fat pad pedicled flap. Subsequently the eight-layered Gentrix® was hydrated as per the manufacturer's recommendation (minimum hydration time of 20 minutes with appropriate orientation of the construction). Inset of the construct was performed using absorbable sutures (Fig. 2) with the application of an overlying Xeroform (Covidien) gauze bolster. Of note, informed surgical consent was obtained for the use of xenogeneic material to ensure that the patient had no personal or religious restrictions on use of a pig-derived material, which was included in his consent form. The bolster was maintained for two weeks and subsequently removed without exposure of bone with a small pinpoint fistula along the mid-portion of the surgical site, which would eventually mucosalise (Fig. 3).

While the bolster was in place, a nasogastric feeding tube was maintained and then removed on the first postoperative visit with the delivery of a transitional obturator. Nine months' after operation, the patient was without evidence of local, regional, or distant disease, had a transitional removable partial denture, was without symptoms consistent with nasal regurgitation, and was also without speech impediments when not wearing his oral prosthesis.

## **Discussion**

Our report highlights the utility of a commercially available, off-the-shelf product, which is a urinary bladder matrix (UBM) that allows for successful mucosalisation of a post-oncological maxillectomy defect. The use of this biological construct achieved an optimal result for our patient and avoided any prolongation of his surgery and recovery due to concerns for his overall medical condition. His reconstructive outcome allowed for the maintenance of the vestibule without any tethering of the lip or loss of vestibular depth, to achieve a full oral rehabilitation with a removable prosthesis. We had a similar favourable outcome using a biological construct as Hazarika et al,<sup>2</sup> who had used a lyophilised amniotic membrane to cover a post-maxillectomy defect.

The major advantage of UBM is that it consists of two layers: the superficial surface which is the basement membrane layer that serves as a barrier between the epithelium and the normal tissue (as well as support for growth of epithelial population of cells); and the second layer, which is deeper (facing the recipient bed) and corresponds to the lamina propria and facilitates the integration of native tissues from within the bed of the defect.<sup>3</sup> In essence, the decellularised porcine urinary bladder matrix act as a biodegradable scaffold that maintains a structure for the formation of new tissue, and the delivery of cells.<sup>4</sup> The biomechanical properties of UBM are afforded by a mixture of structural and functional proteins such as type I collagen, type IV collagen, fibronectin, and glycosaminoglycans.<sup>5-7</sup> Moreover, the physicochemical properties of UBM offer attachment sites for cell surface receptors and a reservoir for signalling factors that modulate various wound healing processes, such as angiogenesis, cell migration, and proliferation.<sup>3,5,8</sup>

In conclusion, we have described a novel application of the use of a commercially-available decellularised urinary bladder extracellular matrix in the reconstruction of a post-

oncological maxillectomy defect creating a prosthetically favourable site for dental rehabilitation and also without the dependence of a patient on a prosthetic obturator due to the absence of an oroantral fistula.

### **Conflict of interest**

We have no conflicts of interest.

### **Ethics statement/confirmation of patient's permission**

Not applicable.

### **References**

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### **Figure legends**

Fig. 1. Intraoperative clinical photograph of the resection bed with identification of the nasal mucosa (asterisk).

Fig. 2. Intraoperative clinical photograph following the inset of Gentrix®.

Fig. 3. Complete mucosalisation of maxillectomy defect without exposed bone or oroantral fistula six months postoperatively.







