and dynamic dialogue among healthcare providers during the initial treatment planning process is crucial to ensuring the provision of optimal rehabilitative care.

Several factors can in uence the cancer surgical treatment plan within the realm of rehabilitation, including:

a) e patient's prognosis and systemic status. b) e potential size and location of the defect. c) Adjunctive therapies (e.g., chemotherapy or radiation) that may a ect the surgical outcome. d) Anticipated changes in function and aesthetics post-cancer surgery, as well as the availability, accessibility, and cost of rehabilitative procedures.

Oral rehabilitation has witnessed continuous evolution since the 1960s, marked by the introduction of new techniques and biomaterials [10]. Notably, osseointegrated implants have emerged as a signi cant advancement in dentistry, serving to replace lost teeth and support prostheses in patients with substantial post-cancer surgery defects.

craniofacial structures, with the highest implant failures occurring in the frontal bone, zygoma, mandible, and nasal maxilla. A lower prevalence of implant failures was noted in the oral maxilla. e use of long xtures, xed retention, and adjuvant hyperbaric oxygen therapy reduced implant failures.

Surgical treatment of malignancies in the oral cavity o en creates an unfavorable anatomic situation for prosthodontic rehabilitation, particularly in cases involving the tongue, oor of the mouth, alveolus, buccal sulcus, and oropharynx. Post-surgical radiotherapy exacerbates oral functioning issues. Surgical interventions a er radiotherapy are preferable to avoid compromised healing, which may lead to the development of radio necrosis in so tissues and bone, increasing the risk of implant loss. Surgical treatment a er radiotherapy requires careful consideration, including measures to prevent implant loss and radio necrosis development, such as antibiotic prophylaxis and/or pre-treatment with hyperbaric oxygen (HBO). Implant placement during ablative surgery should be considered if postoperative radiotherapy is scheduled or likely to be utilized. is approach necessitates thorough pre-surgical examination and multidisciplinary consultation to establish a well-de ned treatment plan. e primary focus should always be on the oncological treatment's curative intent and the prognosis for subsequent prosthodontics rehabilitation. In recent years, immediate surgical reconstruction of complex so -tissue and bone defects resulting from tumor surgery using vascularized free aps has revolutionized post-surgical oral reconstruction and dental prosthetic rehabilitation. e use of osseointegrated dental implants requires selective prosthetic treatment following ablative surgery and has proven bene cial in some cases. e choice between xed or removable prostheses depends on technical considerations such as implant position, aesthetic outcomes, psychological considerations related to the acceptability of a removable prosthesis, and economic factors.

Conclusion