P18 Appropriate Use of Blood Glucose Investigation for Patients Presenting with Acute Cervicofacial Infections

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Introduction/Aims

There are very few reports in the literature detailing the importance of measurement of random blood glucose in patients with acute cervicofacial infections, in order to rule out undiagnosed diabetes. A study by Zhen(2012) concluded that uncontrolled diabetes mellitus is an important indicator of clinical features and outcomes in treating multi-space infections of the oral-maxillofacial region.

Patients with undiagnosed diabetes often present with cervicofacial infections that can require complex management and often a longer hospital stay. Early diagnosis and intervention of this would hopefully therefore improve clinical outcomes. Based upon this paper, an ideal gold standard was set for 100% of all patients with acutely presenting cervicofacial infections to have blood glucose (BG) measurements on admission.

Materials/Methods

30 patients aged 18 years old or over presenting to Pinderfields General Hospital (PGH) with acute cervicofacial infections were identified. Data was collected retrospectively from May-October 2016 using the maxillofacial handovers. The notes were then located and checked for whether a BG measurement had been carried out.

Results/Statistics

Initially, only 17% of patients seen in PGH with acute cervicofacial infections had their BG measured. Data collected for the second cycle of the audit shows a significant improvement in the number of BGs taken.

Conclusions/Clinical Relevance

Blood glucose investigation is uncomplicated and should be practiced by all maxillofacial teams. This audit has proven very beneficial in improving clinical practice. Early detection of undiagnosed diabetes greatly improves patient outcomes.

P30 Patient aftercare and the orthognathic journey at Mid Yorkshire Hospitals Trust: Can we improve it?

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Introduction: The Orthognathic Procedures Commissioning Guide recommends two surgical outpatient reviews in the immediate postoperative period and a period of postsurgical orthodontics is then required on a 6 weekly basis for up to 12 months. The aim of the audit was to ascertain if Orthognathic patients are seen within the recommendation and whether the pathway requires improvement.

Methods: Patient notes were used to review patient attendances and appointments following surgery.

Results: Over the 6 weeks postoperative period two surgical reviews were provided on average (n=123/55-2.2). Our Orthodontic Department provided 2 appointments on average within 6 weeks (99/55). In addition to this there were 32 joint Orthognathic clinic appointments. However there were 8% failed appointments.

Conclusions/Clinical Relevance: In conclusion orthognathic patients were seen within the time stated within the Commissioning Guide recommendations. Our orthodontic unit provided double the amount of appointments required within the first 6 weeks. However the change recommended from this audit is to try to coordinate more follow up appointments on the joint orthognathic clinic to improve efficiency of clinic time and reduce appointment failures. This would also help to improve interdisciplinary communication between consultants in regards to patient management and therefore improving patient care.

P79 A review of the implementation in general dental practice of the 2015 update to NICE antibiotics prophylaxis guidelines for patients at risk of infective endocarditis

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Introduction

In March 2008 NICE released guidelines regarding antibiotic prophylaxis for patients at risk of infective endocarditis (IE) undergoing invasive dental procedures. At that time it was recommended that antibiotic prophylaxis should be avoided in all patients at risk. A review was conducted in 2015, due to a study suggesting a link between the increasing incidence of infective endocarditis and the 2008 guidelines.

The European Society of Cardiology maintains a recommendation that patients at high risk of IE being prescribed prophylactic antibiotics. In 2015 NICE added the word “routinely” to recommendation 1.1.3: Antibiotic prophylaxis against infective endocarditis is not recommended routinely. These conflicting messages can be confusing for both dental care providers and patients.

Methods

General dental practitioners (GDPs) in Mid-Yorkshire were contacted to ascertain their knowledge and implementation of the guidance. 80 questionnaires were sent to dental practices in the local area and the results were assessed.

Results

There was a response rate of over 51% (41), with all GDPs surveyed reporting awareness of and adherence to the NICE 2008 guidelines. 43% of GDPs responded that they were confused by the guidance on antibiotic prophylaxis, with 61% having contacted the patients’ GP or cardiologist for advice. 13% of GDPs were aware of alternative guidance and only 48% knew there had been a review of the 2008 guidelines.

Conclusion

Despite NICE guidelines being in place since 2008 and reviewed in 2015 there appears to be confusion over how patients at risk of infective endocarditis are treated in primary dental care

P260 Prevalence of Infections Following Orthognathic Surgery at Mid-Yorkshire Hospitals Trust and risk factors contributing to this.

Dr Paula Sinnott

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Aims: The purpose of this service evaluation was to investigate the prevalence of infections following orthognathic surgery at Mid-Yorkshire Hospitals trust and to investigate risk factors.

Methods: All patients (n=55) undergoing orthognathic procedures between January 2015 and August 2016 were included in the retrospective evaluation. Medical records were assessed and factors including age, smoking status, operation type and duration of operation were recorded.

Results: 16% (n=9) of patients developed infections postoperatively. Within these 9 patients, 4 operations were on the mandible alone and 5 were bimaxillary osteotomies. 3 infections occurred in the maxilla and 5% (n=3) of patients had infections at two different sites. 55% of patients who developed infections were smokers (n=5). 33% were noted to have poor oral hygiene postoperatively, 1 was associated with an unfavourable split (11%). 1 patient was diabetic. All patients received a single preoperative and two postoperative intravenous doses of antibiotics. In 67% of the patients with infection, this necessitated hardware removal. The average length of surgery (including anaesthetic time) for patients who did not have an infection was 4 hours 11 minutes in comparison to 3 hours 48 minutes for patients who did have an infection.

Clinical Relevance: We are following the national clinical guideline on antibiotic prophylaxis in surgery recommended by SIGN. Postoperative infections are associated with smoking and poor oral hygiene. Patients undergoing orthognathic surgery should be screened and encouraged to cease smoking, at least perioperatively. Patient demographic and operation duration were insignificant.

P261 Is it justifiable to admit Orthognathic surgical patients for less than 23 hours? A single surgeon’s experience

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Dr Mohammed Imran Suida, Mr Sunil Sah

Introduction: To assess how long, on average orthognathic patients are admitted to a ward following their surgery and to investigate if there were any immediate re-admissions or complications after discharging these patients.

Method: 32 patient records were assessed and the number of hours patients were admitted to a ward following surgery was investigated. Hospital admissions were examined to investigate if there were any immediate readmissions or complications.

Results: 91% of patients were discharged within 23 hours or less. 78% (n=25) of patients were discharged after being admitted to a ward for 20 hours or less. This ranged from 16 to 20 hours. 3 patients were discharged after spending 2 nights in hospital due to pre-existing medical comorbidities. Of the surgeries 72% were bimaxillary osteotomies and 28% had single jaw surgery.

Conclusion: 91% of our patients were discharged within 23 hours and there were no immediate readmissions. In the current NHS climate, treating orthognathic patients as 23 hour admissions could help to reduce bed pressures, helping to alleviate stretched NHS resources and reducing the risk of last-minute procedure cancellations. It would facilitate a more efficient and effective use of resources while maintaining patient safety. Shortened hospital stays and earlier mobilisation also can help to reduce the risk of hospital acquired infections and venous thromboembolism.

P262 An Audit of Postoperative Complications following Orthognathic surgery at Mid-Yorkshire Hospitals Trust.

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Introduction: In order to obtain meaningful consent it is important to audit local postoperative complications rather than stating national averages.

Methods: A retrospective review of medical records looking at immediate and longterm complications after orthognathic surgeries were recorded by reviewing patient notes postoperatively from January 2015 to August 2016.

Results: There were 55 patients between the ages of 18 to 42 years old. The average age was 24 years and there were 33 females (60%) and 22 males (40%). Immediate complications include 1 significant postoperative bleed (1.8%), 1 (1.8%) had a deviated nasal septum as a result of surgery. 1 patient (1.8%) had an unfavourable split of the mandible. Long term complications include nine infections postoperatively (16%), 1 case of progressive condylar resorption (1.8%).

Clinical Relevance: In comparison to various studies, our postoperative infection rate is higher than infection rates stated in the Orthognathic Commissioning guide of 11.2% to 3.8%. It has been suggested that long term antibiotics are more effective however we will wait for more studies before changing our practice. We are currently following the SIGN Guidelines. Our complications were lower on other aspects such as unfavourable osteotomy, excessive bleeding and soft tissue damage. Despite the great variety of severe complications reported, their frequency seems to be extremely low. It can be concluded that Orthognathic surgery appears to be a safe procedure.

**Compliance to national guidelines for wisdom teeth**

**extractions**

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**Background:** The removal of wisdom teeth is a common surgical

procedure within dentoalveolar surgery. The reason for extraction

can be associated with a number of pathological changes such

as pericoronitis, caries or cysts. As with all procedures, there are

potential risks and benefits associated with intervention.

**Objectives:** The aim of the retrospective study is to improve care

for patients who are referred into the hospitals for wisdom tooth

removal, by complying with best evidence based practice:

1. The National Institute for Health and Clinical Excellence

(NICE) – Guidance on the extraction ofWisdom Teeth March

2000.

2. Scottish Intercollegiate Guidelines Network (SIGN) Management

of Unerupted and Impacted Third Molar Teeth September

1999.

**Methods:** There were 673 removal procedures carried out at

Pinderfields General Hospital in 2015; a retrospective case note

review was conducted for the last 67 (10%) patients who had a

total of 100 wisdom teeth removed. Comparison was made with

previous results.

**Findings:** From the 98% documented, 90% complied with the

NICE guidelines and 90% with SIGN, a clear increase from the

previous years,75%and80%respectively. 7%of extractions listed

did not comply with either guideline. 2% failed to document a

reason for removal of wisdom teeth.

**Conclusion:** Although there is an overall improvement in the

compliance with either guidance, it does not meet the 100% recommended

local standard. SIGN has been discontinued. If this is

taken in to context, a local agreement needs to be made whether

patients should only be listed according to NICE guidelines.

Midfacial trauma: subtarsal lower-eyelid incision to access and repair orbital floor fractures

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Midfacial trauma: subtarsal lower-eyelid incision to access and repair orbital floor fractures

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Abstract

Full Text

Background: At Mid Yorkshire NHS Trust we encounter a high volume of traumatic injuries to the zygomatic-orbital complex. Historically, at this unit these fractures were accessed and repaired via lower blepharoplasty and subtarsal incisions. These are well-established approaches for several reasons but have the obvious drawbacks of potentially unaesthetic scarring and ectropion. We discuss our experience of using the subtarsal lower-eyelid incision, including the adequacy of exposure, the perioperative and long-term complications and alternative surgical approaches.

Methodology: A retrospective analysis was made of patients receiving orbital floor access and repair during a 24-month period. Complications were determined by reviewing operation notes and subsequent follow up. Analysis of postoperative photographs was also conducted; scarring or ectropion was highlighted.

Discussion: The most common mechanism of injury was via interpersonal violence/assault (78%). We found that 33% of patients had a degree of diplopia following initial injury and in 11% of patients that double vision had remained or worsened one week post surgery. 11% of patients reported ongoing pain from the lower eyelid one month post surgery after wound healing. We had two cases of ectropion (11%) and neither required any further surgical intervention.

Conclusion: There are several well-published surgical approaches to access the orbital floor. Most patient's main concerns preoperatively were based on being left with visible facial scarring. We feel that the subtarsal incision still has a place in accessing orbital floor fractures but there should be a move towards favouring the transconjunctival approach.

**Midfacial trauma: subtarsal lower-eyelid incision to access**

**and repair orbital floor fractures**

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*United Kingdom*

**Background:** At Mid Yorkshire NHS Trust we encounter a high

volume of traumatic injuries to the zygomatic-orbital complex.

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via lower blepharoplasty and subtarsal incisions. These are wellestablished

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**Conclusion:** There are several well-published surgical approaches

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feel that the subtarsal incision still has a place in accessing orbital floor fractures but there should be a move towards favouring the transconjunctival approach.

**Coronectomy of an impacted and submerged second**

**deciduous molar**

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**Abstract:** Coronectomy is a widely accepted technique for

approaching impacted wisdom teeth. The fundamental principle

is to prevent trauma to the inferior dental nerve (IDN). Many literature

publications have demonstrated its positive outcomes. To

the best of my knowledge there is no literature regarding coronectomy

of deciduous teeth. This case report highlights the complex

approach to managing a severely submerged LRE in the mixed

dentition of a 10-year-old female. The report demonstrates and

discusses the combined orthodontic and oral surgery approach

to prevent damage to the IDN and to allow space for orthodontic

movement. This case emphasises how delicate nerve sparing

techniques in the mixed dentition are complex, yet achievable.

Clinical relevance statement: When managing severely submerged

and impacted deciduous second molars, clinicians must

be aware that the options for a coronectomy should carefully be

considered and may be the difference between sparing the nerve

or causing permanent injury.