

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.

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## P261

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

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**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.

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## 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.

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## P263

### 3D Orthognathic Surgery Protocol Evaluation

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**Aims:** The aim of this study was to verify the effectiveness of the orthognathic surgery protocol adopted at Maria Cecilia Hospital, which incorporates the newest available technologies into a patient's orthognathic surgery treatment.

**Methods and Materials:** The 3D workflow for orthognathic surgery is composed of 3 steps:

- 1) 3D data acquisition of the craniofacial complex by cone-beam computed tomography (CBCT- Newtom VGiEVO QR™), dental occlusion surface scanning (Trios Color™ 3Shape), 3d facial scanning (FaceHunter™ Zirkonzahn).