

only conservative recommendations and without any intervention. Miniplates, resorbable miniplates and compression plates were applied to patients who were treated with open approach. Acrylic occlusal plates and arch bars were used for closed treatment.

Conclusion: Reduction and stabilization of mandibular fractures are more difficult in paediatric patients with deciduous and mixed dentition. Minimal invasive techniques such as acrylic plates were preferred for patients with younger ages to obtain better aesthetic and functional results. Features of paediatric mandibles must be taken into account if open approach is performed.

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A 5 year retrospective notes review comparing patterns of trauma in adult cyclists and motorcyclists with facial injuries brought into a major London Trauma Centre between 2010-15

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This study compared the patterns of trauma in helmeted and un helmeted cyclists and motorcyclists, particularly the location of facial fractures, head injuries, and the distribution of serious injuries across the body. Data was collected from Trauma Audit and Research Network, and 140 patients were found between 2010-15 who had been brought into King's College Hospital, London Emergency Department, of which 115 were deemed appropriate. Proportionately, cyclists without helmets suffered on average 1.48 fractures to the face, against 1.96 in cyclists with helmets. This seems counter-intuitive, but can be explained by the different rates of skull fracture and traumatic brain injury (TBI): cyclists with helmets suffered 39% and 43% TBI and skull fracture respectively, while cyclists without helmets suffered 76% and 64% respectively. Cyclists with helmets receive better protection for their head, and therefore if they sustain injuries serious enough to warrant inclusion by TARN, it is more likely to be facial injuries than head injuries; cyclists without helmets therefore proportionately suffer more head injuries. Helmeted motorcyclists suffered less facial fractures (averaging 1.35) and skull fractures (35%), but rates of TBI comparable to un helmeted cyclists and motorcyclists at 65%. A scoring system using Injury Severity Scales was created to calculate the concentration of injuries to the head and face, and it was found that injuries were concentrated around the head in cyclists over motorcyclists, and unhelmeted riders over helmeted. Helmeted motorcyclists were better protected from upper and mid-face fractures over unhelmeted motorcyclists; cyclists with helmets were better protected from upper-face fractures.

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Clinician advice to patients following the surgical repair of orbital-zygomatic complex fractures

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Objective: We commonly encounter traumatic injuries to the head and neck region and surgically repair a significant number of fractures involving the orbital-zygomatic complex.

Post-operatively patients received conflicting information and presented with surgical emphysema following nose blowing or were confused and seeking clarification about the advice offered and how it may affect their occupation or hobbies. We standardised the advice given to minimise confusion and improve patient's clinical outcomes and satisfaction.

Methods: Anonymous questionnaires were sent to OMFS clinicians asking questions about the time patients should be avoiding trauma, nose blowing, flying and driving for, if they were experiencing diplopia. The results were compared to published evidence available.

Results: 15 clinicians completed the anonymous questionnaire with a response rate of 100%. The commonest time frame for avoiding trauma was 6 weeks (42%) and between 7-12 weeks (42%), 16% advised their patients that trauma should be avoided for 3 months or more.

59% advised no nose blowing for two weeks, 25% suggested four weeks and 8.3% advised one week and three weeks respectively.

For avoiding flying 33.3% said two weeks, 25% said there was no need to avoid flying, and the remainder was evenly spread throughout the other available categories.

For patients with diplopia 66.6% advised avoiding driving, 16.6% did not know, 8.3% said attempt to drive to ascertain performance and 8.3% suggested informing the DVLA.

Conclusion: There was a significant variation in the advice given to patients from different clinicians and that both parties may benefit from local guidelines.

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The Need for Inclusion of CT Mandible in Trauma MDCT Protocols

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In 2012, the Department of Health sanctioned the development of 22 specialist trauma centres across England. The aim was to develop a model of care to treat severely injured patients (SIPs), for example those with multiple injuries including head injuries, at a "hub" major trauma centre