

Resident Operative Experience in Surgical Congress

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Received date: May 07, 2021, Manuscript No. IPARS-22-13969; **Editor assigned date:** May 09, 2021, PreQC No. IPARS-22-13969 (PQ); **Reviewed date:** May 23, 2022, QC No. IPARS-22-13969; **Revised date:** May 28, 2021, Manuscript No. IPARS-22-13969 (R); **Published date:** May 29, 2022, DOI: 10.36648/2472-1905.8.3.13

Citation: Wilkinson L (2022) Resident Operative Experience in Surgical Congress. J Aesthet Reconstr Surg Vol.8 No.3:013.

Description

School start period and participation in social activities are the main reasons of this rise. Shortness of condyles and no prominent jaw tip. Besides, children especially younger than 5 years are more protected from trauma by their family. Abnormal growth results in facial asymmetry and deviation of the chin, and may not become apparent for several years. The cause of the actual growth disturbances remains unclear, as different outcomes occur with similar fractures. It is possible that certain children may have lost growth stimuli or suffers from decreased regional vascularity, resulting in growth restriction. Over the age of five, there is an increase in the frequency of mandibular fractures.

The rare occurrence of jaw-area fractures in children is due to the anatomical advantages such as mandibular flexibility. The diagnosis of mandibular fractures in children can be difficult compared to adult patients due to lack of coordination. Firstly, complete anamnesis taken from relatives of the patient, and if possible, from the patient, can guide an examiner in terms of accompanying pathologies, life-threatening conditions and treatment management.

Although lower jaw fractures in the pediatric population are uncommon relatively to the adult age range, mandibular fractures are the most frequently seen in pediatric maxillofacial trauma. For this reason, anamnesis and physical examination are very important during the approach to the fractured mandible.

Significant Asymmetry

Following maxillofacial sensory and motor examination, exophthalmia, rhinorrhea, tore possibly caused by intracranial pathologies and other bone damage findings such as diplopia, infraorbital rim step sign, per orbital ecchymosis and edema should be evaluated without omission.

Although X-ray is the first applied examination among the radiological imaging techniques to support the diagnosis, computerized tomography is more valuable in terms of reflecting a localization of the fracture, presence of the displaced fracture and relation of the fracture with other anatomical contiguities in three dimensions.

Significant asymmetry during the examination, swelling and ecchymosis in the preauricular region can give hints about a location of the fracture and the diagnosis. Muscle spasm and pain resulting from mandibular fracture may be encountered with trismus. This functional therapy can be as simple as elastics in conjunction with orthodontic appliances or occlusal splints, or it may require a formal functional appliance, which are placed by orthodontists. In growing children, over a period of time, a functional appliance can correct a malocclusion caused by a condylar fracture and help correct abnormal mandibular function.

A deviation, malocclusion and limited mobility may be seen when opening and closing the mouth in the jaw examination. High estrogenic potential of pediatric mandible allows nonsurgical management to be successful in younger patients with conservative approaches. Maxillofacial surgeons generally justify the use of plate and screw-type internal fixation to be reserved for difficult fractures. Specific subsets of mandibular fractures, including displaced fractures of the body or angle, fractures of the condylar neck with significant barriers to movement, complex fractures, and fractures in non-tooth bearing areas necessitate open reduction and internal fixation.

Fracture Localization in Pediatric Patients

As the most common fracture localization in pediatric patients, the disruption in the golf club appearance of the condyle in computerized tomography imaging is highly diagnostic. Titanium manipulates are still widely used despite the possible benefits of resorbable plates.

Titanium plates demonstrate good long-term biocompatibility, have favorable physical properties, can be easily manipulated intraoperative to treat the fracture, and have the benefit of several decades of predictable use in facial fracture fixation.

Complications such as infection and nonunion usually occur due to factors such as inadequate reduction during surgery, failure to achieve stabilization or failure to apply a healthy fixation. In case of significant malocclusion or nonunion open reduction and internal fixation should be performed by secondary surgical operation.

Patients who exhibit persistent malocclusion after unilateral or bilateral condylar fractures that have been treated with MMF can often further be treated nonsurgically; however, some type of functional therapy is recommended to address the abnormal occlusal relationship. Maintaining appropriate range of motion at the TMJ is important in maintaining proper mandibular growth, as well as avoiding alkalosis and TMJ dysfunction. In all cases, restoring facial symmetry is a very difficult challenge in these patients, and may require additional interventions that may range from fat grafting, to orthodontics to combined orthodontic-orthographic surgery approaches.

Variable chemical compositions of these plates attempt to balance an expedient degradation process while minimizing local foreign-body inflammatory reactions. Typically their strength holds for 4 to 6 weeks while the complete degradation process may take 1 to 2 years. 31 patients with 43 fractures of the mandible were enrolled in the study. Patient age ranged from 20 months to 14 years with a mean of 8.05 years. Fractures included 26 (60.4%) symphysis-parasymphysis fractures, 12 (27.9%) condylar-sub condylar fractures, and 5 (11.6%) angle and ramus fractures.

We used both systems of metallic and resorbable hardware for fixation of pediatric mandible fractures. Limited number of cases and follow-up demonstrated no difference between the stability and healing capacity of the two systems. However, ongoing studies demonstrating the advantages of the resorbable plates indicate that they are going to be preferred more in the future.

Resorbable materials have the advantage of avoidance of secondary removal operations. Limited number of long-term studies and high cost when compared to the metallic hardware are among the drawbacks of biodegradable systems.

Inter maxillary fixation was used in nine patients with metallic plates and in six patients with resorbable plates. Metallic plates and screws were used in nineteen (62.7%) patients with 27 fractures and resorbable plates and screws in twelve (37.2%) patients with 16 fractures. Resorbable plates cost more than the metallic ones; however, when the secondary operations are included in the total cost, resorbable plates were favorable.

As mandibular growth and complication parameters are similar in both groups, resorbable plates are favored due to avoidance of potential odontogenic injury, elimination of long-term foreign body retention and provision of adequate stability for rapid bone healing. These characteristics prove particularly ideal for the pediatric population, in which bone growth and turnover creates potential problems for non-resorbable, permanent plates.

However, learning curve and concerns for decreased stability against heavy forces of mastication accompanied with the resorbable plates when compared to the metallic ones should be kept in mind. Growth abnormalities may occur as result of fracture dislocation of condyle due to elimination of 'functional matrix' of lateral pterygoid function, trismus or ankylosis. Methods of dental alveolar stabilization also require some reforms.