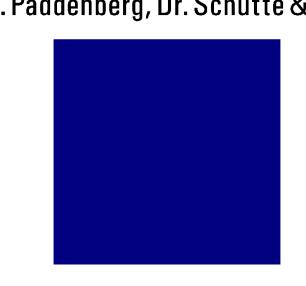
# Risk management after orthognatic surgery









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#### Aim

In this examination we identify and systemize postoperative risks and problems of orthognatic surgery to define the orthodontist's role in such cases.

#### Materials (Subjects) and Method

Up to 80 cases of orthognatic surgery are treated in the authors' office per annum. Sometimes postoperative problems appear to be evaluated and treated. Is it possible to systemize these risks in a qualitative way and to define the special roles of the orthodontist and the surgeon? We tried to build a matrix added with a classification in some cases.

problem / risk	orthodontic treatment	orthodontic/surgical	surgical treatment
		treatment	
bad split			1.surgical fixation
(caput / collum)			
	3. without significant dislocation: conservative / activator to keep the vertical dimension		-
easing of screws / fracture		extended immobilisation / conti-	surgical reattachment
osteosynthesismaterial		nuous splintcontrol	
early			
easing of screws late	monitoring splint / occlusion con-		
	servative / early screws-ex		
	reattachment of screw		
	(if possible)		
tractor)			surgical refixation
easing of TPD late	TPA		
	2 paramedian bone-born locked TADs		
	Hybridhyrax		
			surgical refixation
	splint modification		
to unpropicious splint	splint ex		
insufficient occlusion in	elastics		
spite of appropriate splint			
design - moderate	splint modification		
severe	elastics		
	enhanced dentoalveolar compen-		
	sation (where appropriate with		
	premolar - or incisor extraction)		
	acceptance of compromise treat-		
	ment outcome		
			re-surgery
infection / inflammatory	lavage		surgical routine treatment
•	flop / drainage		
	antibiosis if necessary		
allergic reaction (for example elastics, etc.)	change to hypoallergical material		

## Results

The Matrix of risk management relating to orthognatic surgery is a tripartition one: only orthodontic, combined orthodontic-surgical and only surgical intervention.

The theoretical view identified the orthodontist as the gatekeeper to initiate the suitable intervention for the patients. The communication among orthodontist and surgeon is the pre-condition.

## Conclusion

In a former survey the main author veryfied the part of the orthodontist as the patients' essential contact in combined therapy. The systematical look at the postsurgical risk management proves this role.