Tips for GP trainees working in oral and maxillofacial surgery

Oral and maxillofacial surgery is a unique specialty in its requirements for degrees in both medicine and dentistry. The dental element, especially when on-call, cannot be ignored. Many of the clinical procedures that you may be expected to competently carry out, involve the oral cavity — a foreign, cavernous black hole to even the well-seasoned medic — and a high degree of manual dexterity. Skills and knowledge learned in previous rotations are not always transferrable. The language is different. Patients will complain of problems with their teeth. Don't let this put you off — persevere, and a fascinating, elegant, and hugely varied specialty will embrace you. You will quickly become intimate with osteotomies, cranioplasties, tracheostomies, and mandibulectomies and converse in a tongue unknown to your hospital colleagues, using terms such as 'Le Fort', 'Ludwig's', and 'SOF syndrome' with reckless abandon.

You will work with paediatric patients, older patients, toothy patients, and violent patients, both in the emergency and elective setting. Your days can fluctuate from reconstructing the polytrauma victims' mid face and orbit to correcting cleft lip and palate deformity, to assisting/observing microvascular free flap surgery in a patient with extensive head and neck cancer.

Enter with an open mind. Don't be afraid to ask for help, and first and foremost, learn tooth number and notation. The following tips are designed to give the GP trainee who finds themselves in an oral and maxillofacial surgical job both a taster and a head start in the scope covered by the specialty. Enjoy.

FACIAL INFECTIONS

1. Feel the floor of the mouth in ALL dento-facial infections and abscesses. This may help in distinguishing the minor from potentially life-threatening case.
2. The following facial infection cases need further investigation and probable admission: previous course of antibiotics with little/no success; difficulty eating,

drinking, talking, breathing (not in order of importance); erythema approaching the eye, with or without visual disturbance; diabetes; firm floor of mouth; systemic features — pyrexia, tachycardia; obvious abscesses; decreased mouth opening (trismus); drooling; and suspected Ludwig's angina.

3. Tap on or manually move suspect teeth, if this is exquisitely tender, the patient may have a dental abscess.
4. Facial infections CAN kill.
5. Measure the blood glucose in all facial infections.
6. Feel for lymphadenopathy.
7. Contrary to popular prescribing, metronidazole isn't needed in addition to augmentin.
8. The dose of augmentin orally is 625 mg three times a day.

TRAUMA

9. All lost teeth need to be accounted for — if this is not possible, the patient needs a chest radiograph.
10. Exclude serious head injuries in all cases of maxillofacial trauma. Red flags include: memory loss; unconsciousness/fluctuating consciousness; nausea/vomiting; visual disturbance; and headache that doesn't improve with simple analgesics.
11. Exclude cervical spine injuries in all cases of maxillofacial trauma.
12. Store avulsed teeth in milk, saline, or saliva (not yours). They need to be re-implanted within an hour to maximise chance of survival, ideally within 20 minutes.
13. Assess the facial nerve and trigeminal nerve in facial trauma and lacerations.
14. Look for a septal haematoma in nasal fractures, consider it a cauliflower ear in the nose and drain accordingly and urgently.
15. Assess eye movement, visual acuity, and cheek paraesthesia in suspected orbital fractures. Investigate urgently in children

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Submitted: 6 May 2011; **final acceptance:** 23 May 2011.

©British Journal of General Practice 2012; 62: 50–51.

DOI: 10.3399/bjgp12X616490

as increased incidence of (permanent) rectus muscle ischaemia.

16. If a mandibular fracture is visualised on X-ray, look for another. Look again.
17. Raccoon/panda eyes and Battle's sign do NOT refer to smudged mascara after a heated verbal exchange, especially when accompanied by CSF rhinorrhoea/otorrhoea. Know their significance.
18. René Le Fort is not a strong blue French cheese. Learn his classification and recognise the fracture clinically and radiographically.
19. Beware the intoxicated patient. Not all signs and symptoms can be attributed to alcohol/drugs.

ONCOLOGY

20. Malignant melanoma, squamous cell carcinomas, and basal cell carcinomas can be managed by the maxillofacial surgeon, along with head and neck oncology, cleft lip and palate, and facial aesthetic surgery.
21. Firm cervical lymphadenopathy requires urgent referral, not just in smokers. Thoroughly examine the aero-digestive tract.
22. Learn to assess a flap. Remember it has an arterial component and a venous component. A good inflow with occluded outflow is of little use. The same is true of the reverse.
23. If you even contemplate calling for senior advice, call. A head and neck surgeon will not be irritated if called to review a patient's flap but will rightly be aggrieved if the flap that took 15 hours to carefully anastomose has died an untimely and potentially reversible death through negligence or uncertainty.
24. Investigate all intraoral lesions and ulcers lasting longer than 3 weeks, especially (but not confined to) smokers and alcoholics.

GENERAL

25. Find and organise the maxillofacial cupboard. Familiarise yourself with the materials within; composite, etch and bond, light-curing gun, splinting wire, flat-plastic.
26. The maximum safe dose of lignocaine with and without adrenaline is 7 mg/kg and 3 mg/kg respectively.
27. Embrace being a 'proper doctor' among a majority dentist-only junior grade. Baffle and astound with echocardiograph interpretation.
28. Become a veritable seamstress. Patients will notice if your wound closure is more

Nightmare on Elm Street than Harley Street.

29. Learn to interpret (and pronounce) the orthopantomogram (OPG). It is imperative in suspected mandibular fractures and odontogenic facial infections.
30. Learn the number and whereabouts of your local acute dental clinic (ADC).
31. Learn the scope of an oral and maxillofacial surgeon. This will help in appropriate referral and save potential embarrassment.

DENTAL

32. Recognise and know what a 'dry socket' is. Know the usual suspects: mandibular wisdom teeth; smokers; women on the oral contraceptive pill; history of a difficult extraction requiring lots of local anaesthesia; poor adherence to post-operative instructions; foul taste and smell arising from patients' mouth; and past history of dry socket.
33. Isolated dental pain needn't always be referred to the maxfac surgeon. Besides, you may have missed a myocardial infarction.
34. Learn to wield the dental syringe like a magician's wand. The infra-orbital, inferior alveolar, mental, and long buccal nerve blocks should all be within your repertoire.
35. Dental mal/occlusion isn't always overrated. If present and associated with trauma, this may suggest a mandibular fracture.

PAEDIATRICS

36. Know at what age children have lost all of their deciduous teeth — this saves embarrassment and future teeth when naively attempting to re-implant avulsed primary teeth.
37. Cleft lip and palate requires a multidisciplinary approach and includes the involvement of surgeons, orthodontists, speech and language therapists, and psychologists.
38. Have a low threshold for admitting paediatric facial lacerations.

ANATOMY

39. The inferior rectus has little to do with the distal alimentary system.
40. Learn the anatomy of the 5th (trigeminal) and 7th (facial) cranial nerves.
41. Acquire a human skull and learn the anatomy of the head and neck ... well.
42. The vermilion border is an important anatomical landmark requiring accurate suturing when crossed by facial lacerations.

Provenance

Freely submitted; externally peer reviewed.

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