Parameters of Care:
AAOMS Clinical Practice Guidelines
for Oral and Maxillofacial Surgery
(AAOMS ParCare) Sixth Edition 2017

DENTOALVEOLAR SURGERY

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THIS SECTION IS 1 OF 11 CLINICAL SECTIONS INCLUDED IN AAOMS PARCARE 2017, WHICH IS VIEWED AS A LIVING DOCUMENT APPLICABLE TO THE PRACTICE OF ORAL AND MAXILLOFACIAL SURGERY. IT WILL BE UPDATED AT DESIGNATED INTERVALS TO REFLECT NEW INFORMATION CONCERNING THE PRACTICE OF ORAL AND MAXILLOFACIAL SURGERY

INTRODUCTION

Dentoalveolar surgery encompasses those surgical procedures that involve teeth and supporting structures associated with the oral cavity. This section includes the management of: odontogenic infections; erupted, unerupted, and impacted teeth; third molars; periradicular pathology; and the revision, reduction, and excision of deformities and defects of the dentoalveolar complex. Implant surgery, traumatic injuries, pathologic conditions, and reconstructive surgery that are applicable to the dentoalveolar complex are not included. These topics are addressed in the chapters on *Dental and Craniomaxillofacial Implant Surgery, Trauma Surgery, Diagnosis and Management of Pathological Conditions,* and *Reconstructive Surgery*, respectively. The subject of osteomyelitis is included in the *Diagnosis and Management of Pathological Conditions* chapter.

An understanding of basic surgical principles, as well as an awareness and appreciation of the extent of the biomedical literature, is necessary for the proper interpretation and appreciation of the Dentoalveolar Surgery section.

In the future, significant advances will occur in biomaterials, diagnostic techniques, and management modalities, and each will make an impact on the achievement of favorable outcomes. Such potential for change requires that this document remain dynamic, updated, and revised to include valid new information applicable to patient care.

GENERAL CRITERIA, PARAMETERS, AND CONSIDERATIONS FOR DENTOALVEOLAR SURGERY

INFORMED CONSENT: All surgery must be preceded by the patient's or legal guardian's consent, unless an emergent situation dictates otherwise. Emergent circumstances should be documented in the patient's record. Informed consent is obtained after the patient or the legal guardian has been informed of the indications for the procedure(s), the goals of treatment, the known benefits and risks of the procedure(s), the factors that may affect the risk, the treatment options, and the favorable outcomes.

PERIOPERATIVE ANTIBIOTIC THERAPY: In certain circumstances, the use of oral antimicrobial rinses, and systemic antibiotics may be indicated to lower the probability of infections related to surgery. The decision to employ prophylactic perioperative antibiotics is at the discretion of the treating surgeon and should be based on the patient's clinical condition as well as other comorbidities which may be present.

DEALING WITH NEUROLOGIC DEFECTS: Injuries to the terminal branches of the trigeminal nerve (eg, lingual, inferior alveolar, long buccal nerves), as well as the facial nerve, are known risks of oral and maxillofacial surgery. It should be noted that the presence of a pathologic craniomaxillofacial condition, dentoskeletal or craniofacial abnormality, or traumatic craniomaxillofacial injury may result in nerve injury prior to surgical management. In addition, the use of local anesthesia (eg, mandibular block) may increase the risk of nerve injury. Most nerve injuries resolve spontaneously, but some do not, and these may require consideration for non-surgical and/or surgical intervention. Microneurosurgical repair should be considered when the disability is of concern to the patient, and there is clinical evidence of moderate, severe, or complete neurosensory impairment of various areas of the orofacial region (eg, lips, chin, tongue); paresis or paralysis of facial muscles; loss, decreased, or abnormal taste sensation; or neuropathic pain of peripheral origin. Surgical repair should incorporate specialized microsurgical techniques (eg, operating magnification, nerve grafting), when indicated. Also see the *Reconstructive Surgery* chapter.

USE OF IMAGING MODALITIES: Imaging modalities may include panoramic radiograph, periapical and/or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable) should be followed. For growing patients, panoramic radiographs are usually current if within one year for the assessment of third molar position, indications for extraction and surgical planning. Adult patients without changes in expected pathology or other outcomes may need a less frequent updating of radiographs. The use of cone beam radiographs should be based on a specific need for information not able to be obtained from two dimensional imaging with a lower radiation exposure.

DOCUMENTATION: The *AAOMS ParCare 2017* includes documentation of objective findings, diagnoses, and patient management interventions. *The ultimate judgment regarding the appropriateness of any specific procedure must be made by the individual surgeon in light of the circumstances presented by each patient. Understandably, there may be good clinical reasons to deviate from these parameters. When a surgeon chooses to deviate from an applicable parameter based on the circumstances of a particular patient, he/she is well advised to note in the patient's record the reason for the procedure followed. Moreover, it should be understood that adherence to the parameters does not guarantee a favorable outcome.*