# BOS/BAOMS Minimum Dataset Proforma for Surgical-Orthodontic Patients

Patient name: ……
*(or use sticky label)*
Hospital number: ……...

Surgeon's initials: ……

Orthodontist's initials: ……

**Key Dates**

| | | | |
|---|---|---|---|
| Date of 1st Combined Clinic appt. | | Date of osteotomy | |
| Date of start of orthodontics | | Date of orthodontic debond | |
| Date of 3rd molars removal | | Date of any 2° surgery | |

***PLEASE ADD DATE AND INITIALS IN EACH BOX AS APPROPRIATE*** *(see notes overleaf)*

| | Radiographs | | | | | | |
|---|---|---|---|---|---|---|---|
| | 90° Lateral Cephalogram[1] | OPT[4] | Study models[5] | I/O & E/O Photographs | Clinical Measurements[6] *(details in notes)* | Altered sensation? [7] *(delete one)* | BOS Patient questionnaire completed ? [8] |
| Pre-treatment | | | | | | Yes / No<br>Left / Right<br>**PCO:** Y / N | Yes / No |
| End of pre-surgical orthodontics (*i.e.* surgical planning) | | | | | | Yes / No<br>Left / Right<br>**PCO:** Y / N | |
| "Immediately" post-surgery | | | | | | Yes / No<br>Left / Right<br>**PCO:** Y / N | |
| 1-3 weeks post-surgery (after wafer or IMF removal) | | | | | | Yes / No<br>Left / Right<br>**PCO:** Y / N | |
| Pre-debond[2] or "circa" debond | *(if >6/12 ortho)* | | | | | Yes / No<br>Left / Right<br>**PCO:** Y / N | Yes / No |
| 2 years post-orthodontic debond[3] | | | | | | Yes / No<br>Left / Right<br>**PCO:** Y / N | Yes / No |

## Case Summary *(circle as appropriate)*

| | | | |
|---|---|---|---|
| **A-P** | Skeletal I | Skeletal II | Skeletal III |
| **F-M Angle** | Normal | Reduced | Increased |
| **Surgical operation** | Mandible only | Maxilla only | Bimaxillary |

**Comments:** *(incl. further details, AOB, surgical expansion, genioplasty, return to theatre, etc.)*

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# EXPLANATORY NOTES

Clinical records provide data for many purposes including audit, research and treatment planning. This advisory dataset should be viewed as the *"minimum"* required during the course of treatment for orthognathic patients. This data will enable well-designed prospective research projects to supply us with much-needed scientific evidence of our treatment outcomes as well as valuable information to assist us in the management of our future orthognathic patients. There is a paucity of good scientific evidence on this subject. Currently, record collecting for orthognathic patients is being done in a rather haphazard and incoherent manner with units having varying "protocols". This is an attempt to rationalise our record collection. It is important to be able to "justify" all the proposed timings of the records being collected. The need for such records must be clearly explained to the patient/parent as part of the overall consent process. Some units may decide to develop a specifically worded written consent form and/or patient information sheet for this purpose.

This dataset needs to be kept under regular review so that adjustments can be made as "evidence" from future well-constructed prospective research studies appears in the literature. This minimum dataset should be viewed as an evolving process that is open to refinement as new studies/evidence becomes available. For example, in time, the "2-years post-treatment records" may need to be amended by individual treatment centres if their researched results show that a *particular* surgical procedure by a *particular* surgeon/orthodontist "team" is stable. Routine record collection at this time point may then be of questionable benefit and would need to be re-examined. Operator (surgeon & orthodontist) variability is, however, a significant issue and this needs to be regularly evaluated.

**Lateral Cephalograms**[1]
An "immediate" post-operative lateral cephalogram should not be taken routinely. Only take in "concern" cases where the post-surgical maxilla position is in question and a quick return to theatre is likely.

The request for a lateral cephalogram taken at 1-3 weeks post-surgery should be under the direction of the orthodontist. Any surgical wafer used should be removed prior to this x-ray exposure and it should be carried out on the same cephalostat as previously used. The teeth should be in occlusion with much of the post-op swelling subsided. This view will record a "true" and meaningful post-op position of the jaws *prior to* significant post-surgery orthodontic mechanics, such as intermaxillary elastic traction, commencing. In units using IMF for 4-6 weeks, the taking of this film should be delayed until its release.

[2]A pre-debond lateral cephalogram is conditional upon the post-surgical orthodontic phase exceeding 6 months. This view will record the "final" post-op position of the jaws at the completion of post-surgical orthodontics. For patients with shorter periods (<6 months) of post-surgical orthodontics, the "1-3 week post-op" cephalogram should suffice.

[3]The limited available literature on long-term treatment outcomes for orthognathic patients suggests that the majority of surgical changes are stable 12-18 months after surgery. At 1-year post-surgery, a significant number of patients may have only recently completed their post-surgical orthodontic treatment. A reasonable compromise is to take *all* the "final" records (including cephalogram) 2-years post-orthodontic debond *i.e.* a minimum of 1 year out of retention, to assess the final outcome and any "relapse" associated with surgical-orthodontics.

**OPT**[4]
At the end of the pre-surgical orthodontic phase, there is no need for an OPT if 8's previously extracted as a result of the pre-treatment OPT. If 8's haven't been extracted and are to be removed at the time of surgery, then obtain new OPT.
The "immediate" post-op OPT is the responsibility of the surgeon.

**Study Models**[5]
The pre-surgical planning models are "working" models. It is not necessary to keep these "mock-surgery" models long-term.

**Clinical Measurements**[6]
The primary clinical document is the written record. Advice has previously been published with regard to a minimum data set for clinical measurements and demographic details of the patient. Many hospital & community clinics use their own particular data collection sheets. The proforma should act as an "aide-memoire" with further details entered in the patient's clinical notes.

**Altered Sensation**[7]
A "baseline" recording of any altered facial/intra-oral sensation present prior to starting treatment is good practice. Obtain a pre-osteotomy recording of any "altered sensation" as well. Sensation may have been adversely affected by earlier removal of third molars. There is no standardised model of testing for altered sensation currently available. A simple recording can be indicated on the proforma with further details and drawing (if applicable) made in the patient's clinical notes. Subjective testing is sufficient with an additional note made as to whether the altered sensation is an actual concern to the patient.

**Patient Questionnaires**[8]
This aspect of patient assessment and treatment outcome is currently awaiting national approval. It is hoped that a nationally agreed and validated patient "satisfaction" questionnaire will be available next year on the BOS website. In time, a "psychological-based" questionnaire will also be available.