

The general practice residency program was able to arrange a trip to the maxillofacial surgery unit in Birmingham, UK in early February of this year. The 2 week trip gave the opportunity to observe maxillofacial surgeons performing the full range of surgeries from orthognathic to repair of craniofacial deformities to cancer resections. Time was spent with the maxillofacial surgeons (“consultants”), the surgical residents (“registrars”) and the hospital dentistry residents (“surgical house officers” or “SHO’s”).

The consultants and registrars had attended both dental and medical school, with time as an SHO between the two. They spend 5 years in surgical training as a registrar in Maxillofacial surgery, before spending an additional two years rotating through other surgical specialties. The majority of maxillofacial surgeons become consultants in their late 30’s to early 40’s. The schooling is almost fully covered and they are paid a reasonable salary during their training, negating any need to go into debt.

The SHO’s have all completed dental school, and then taken a job working in a hospital setting. This makes them eligible to write a set of entrance exams specialty dental programs. They are the equivalent to the general practice residents in Vancouver, with some large differences. The job of an SHO is extremely varied and they function in the hospital environment as a medical graduate. They may have to take blood, insert a catheter, manage a patients fluids post-surgery, extract teeth, and help manage a pan-facial trauma case all in one day. They look after the day to day running of the patients on the ward. Obviously there is steep learning curve for a new dental grad, and to aid in this, a weekend course is held twice a year to help lessen the culture shock. I was able to attend the course, which covered many of the relevant skills needed, including taking an ECG, a trauma examination and heart sounds on dummies, an overview of fluid management, changing of tracheostomies and many more. Throughout the program, a culture of asking questions before attempting was promoted.

The hospitals involved with the rotation included Solihull, Queen Elizabeth and the Birmingham children’s hospital.

Solihull hospital is the major trauma center in the area and serves approximately 2 million people. The consultant on call has no other routine duties except to aid the registrars and SHO’s in treating trauma cases. This allows quick treatment and excellent supervision and training of the registrars and SHO’s. During 2004, the maxillofacial unit, treated 200 mandibular fractures, 150 zygomatic/orbital floor fractures, 30 maxillary fractures and 19 nasoethmoid/frontal bone fractures.

At Queen Elizabeth hospital, the maxillofacial unit was fully integrated, unlike here in Vancouver. They shared a ward with ENT and had their own operating theatre, which was in use five days a week. Three days a week, the operating theatre was used for major cancer resections from the oral cavity, head or neck. These involve neck dissections and are repaired using free pedicle grafts from the arm, leg or back. The patients will have a tracheostomy tube place and will spend a week in hospital after their surgery, and it is the job of the SHO’s to look after them while they are there. Implants are used in the majority of cases, with 80 extra-oral and 100 intra-oral implants placed in 2004, with no charge to the patient. On the remaining two days a week, orthognathic surgery, dental extractions and other routine dental surgeries would take place in the operating theatre.

Children’s hospital has a maxillofacial consultant acting as an integral part of craniofacial surgeries. The surgeries I was able to be assist on, involved infants with cranial synostosis, whereby the bony sutures of the skull have fused too early, causing increased intracranial pressure. The maxillofacial surgeon worked very closely with the neurosurgery unit, and a neurosurgery registrar assisted the maxillofacial surgeon. The procedures allowed the brain to expand and the child to develop in a normal fashion.

I personally was able to assist and observe on five oncology surgeries. These involved neck dissections, cancer resections and the placement of free flaps. I also witnessed three craniofacial synostosis surgeries. Time out of the operating theatre was spent in the oncology and craniofacial clinics for the follow-up and examination of new patients. Dr Sat Parmar, the main oncology surgeon, would see on average 40 patients in an afternoon at his clinic. The patients ranged from patients who were two years post-surgery and had facial prosthetics fabricated for them, to new referrals for suspected cancers.

Overall the trip showed the full extent to which dental training can reach, and the integration of the maxillofacial unit into the hospital. A huge difference in comparison to Vancouver, where facial trauma is referred to plastics or ENT, oncology surgeries are done by ENT, and implants are for the patient to pay for. The experience was eye-opening and the hospitality second to none.

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