SHORT COMMENTARY

Moroccan dental surgery

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ABSTRACT

The main focus of oral and Maxillofacial Surgery (OMFS) is the clinical care of diseases that can be treated surgically and affect the face, jaws, mouth, and associated structures. Treatment of facial injuries, trauma, cancer, reconstructions, and deformities such cleft lip and palate, as well as oral and orthognathic surgery, are the main areas of attention for this speciality. In difficult head and neck anatomical regions, it calls for a variety of precise surgical techniques for both hard and soft tissues.

Key Words: *Craniofacial surgery; Orthognathic surgery; Maxillo-mandibular complex; Orthodontic*

INTRODUCTION

It is generally acknowledged that this field of study initially belonged to dentistry and that it dates back to World War I. Over time, it will cover a wider range of increasingly intricate and extensive surgical operations. Since the oro-facial junction might involve a variety of skills, a long struggle between this specialty's dental and medical identities begins at this point. This discussion results in the studies being organized uniquely for each nation. As a result, there are four training pathways for oral and maxillofacial surgery in the world that just requires a dental degree; that also requires a medical degree, but with no or little dental training; that also requires a combination of dental and medical education, but not degree based (stomatology). There are several training organizations in European nations; for example, this specialty is exclusively available to doctors in France and Spain and doesn't require dental training, whereas in Nordic nations (Denmark, Sweden, Norway, and Finland), no medical degree is necessary. In the most recent countries, the initial training period is years long if it is just dental or medical; however, if it is dual, the period is shorter, lasting only a few years. Several other nations use the DUAL approach of training. Specific to oral and maxillofacial surgery, which requires two full undergraduate degrees, is the idea of duality in training. (medical and dental). In Morocco, a setup of two specialties—one dentistry and the other medical has been adopted [1].

Dentists are permitted to do oral surgery, but only physicians or doctors are permitted to perform oral and maxillofacial surgery. We can see from the title that oral surgery and oral and maxillo-facial surgery are related. The most recent do, in fact, incorporate the first. The term "oral surgery" in Morocco is actually "dental surgery." (translated from French). This name is distinctly out of date. Additionally, many nations have waived the "Buccal Surgery" descriptor in favor of the "Oral Surgery."

The adoption of the new title and the consideration that went into it are not random; they allow for the opening of the field's boundaries and demonstrate the breadth of the abilities that may be learned.

As a result, we discover that the American association of oral and maxillofacial surgeons formally changed its name years earlier from the association of oral surgeons, with the flexibility of expanding its field of practice cited as the change's justification [2-4].

Surgery-first approach

Orthographic surgery followed by postoperative orthodontic therapy without preoperative orthodontic treatment is the definition of the "surgery-first method". The term "modified-surgery strategy" refers to preoperative orthodontic therapy that is minimized to fewer than six months [5].

SURGICAL PLANNING

Virtual surgical planning

According to other papers, the surgery-first approach offers the advantages of shortening overall treatment times, favoring postoperative orthodontics, enhancing facial aesthetics early on, and treating OSA early on [6]. The surgery-first approach is typically appropriate for patients who do not need extensive preoperative care, such as those who have:

- well-aligned to mildly crowded anterior teeth,
- a flat to mild Spee curve,
- normal to mildly proclined or retro lined incisors, and
- a minimal transverse discrepancy.

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The resident in oral surgery must be capable of managing a number of specialties by the time they complete their training, including oral and maxillofacial traumatology, tumor excision, implant ology, and peri-implant surgery. But as soon as the instruction begins, the practical level's limitations become apparent. His comprehensive training organization in Morocco is in opposition with the law, the subject is still sterile, and the locals still have a yearning for knowledge [8].

It is no longer necessary to question the need for this specialty, but how can we structure and improve a specialism if we are already constrained by its name? How is it feasible that oral and maxillofacial surgery is solely considered to require dental training in other nations? Do they not have a foundation in dentistry and have success in the oral and maxillofacial field? With dual training, other nations haven't been liberated from these skill gaps, compensation plans haven't been created, and dentists and physicians work in perfect harmony.

As an academic, I believe it is time to start a discussion about this specialty and to begin by changing the name from "dental surgery" to "oral surgery," in order to align ourselves with the world rank and be able to review the fields of competition and develop a structured academic approach based on compensation of practical and theoretical knowledge in accordance with the dentist's initial training for a solid and widened practice.

would provide an example. The national diploma of oral surgery was adopted in France a few years ago, and despite the turbulent beginnings, the country is now optimistically moving towards better oral surgery practice. The national academy of surgery in France has recognized oral surgery, and there are increasingly more calls for the fields of competence to be expanded.

When will it be Morocco's turn to initiate change?

The choice of whether to operate on the mandible or maxilla first during two-jaw orthographic surgery utilizing the double-splint approach is still debatable and is determined by how comfortable the surgeon is with the surgical technique and sequence. A complete Ledford I osteotomy is performed first, with the maxillary segment being repositioned using an intermediate splint. Next, a complete BSSO is performed, and the distal section of the mandible is repositioned using a final splint. Wide mouth openings are not necessary for complete BSSO since they could change the fixed maxillary position. the maxilla-first sequence was more accurate in the setting of targeted maxillary impaction and with the majority of surgical manoeuvres [9,10].

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