SHORT COMMUNICATION

Morocco's oral surgery virtual surgery planning

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ABSTRACT

The primary goal of Oral and Maxillofacial Surgery (OMFS) is to provide therapeutic care for illnesses of the face, jaws, mouth, and associated tissues that can be treated surgically. Facial injury and trauma treatment. This speciality focuses on cancer, reconstructions, and deformities like as cleft lip and palate, as well as oral and orthognathic surgery. It necessitates a variety of precision surgical procedures for both hard and soft tissues in tough head and neck anatomical locations.

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

INTRODUCTION

It is widely accepted that this branch of study originated in dentistry and dates back to World War I. It will eventually encompass a broader spectrum of increasingly complex and extensive surgical procedures. Because the oro-facial junction may require a range of talents, a protracted battle between this specialty's dental and medical identities begins here. As a result of this dialogue, each country's studies are organised uniquely. As a result, the globe has four training tracks for oral and maxillofacial surgery.

that just requires a dental degree; that also requires a medical degree but little or little dental training; - that also requires a combination of dental and medical education but not a degree (stomatology). There are numerous training organisations in European countries; for example, this speciality is only open to doctors in France and Spain and does not require dental training, although no medical degree is required in the Nordic countries (Denmark, Sweden, Norway, and Finland) [1,2]. The initial training term in the most recent countries is years long if it is solely dental or medical; however, if it is dual, the period is much shorter, lasting only a few years. Several other countries employ the DUAL training method. The concept of duality in training is unique to oral and maxillofacial surgery, which needs two full undergraduate degrees. (Medical and dental services). In Morocco, two specialties—one dental and one medical—have been established. Dentists can do oral surgery, but only physicians or doctors can perform oral and maxillofacial surgery. The title suggests that oral surgery and oral and maxillofacial surgery are connected [3-5]. In fact, the most current contains the first.

In Morocco, the term "oral surgery" is actually "dental surgery." This name is clearly out of date. Furthermore, many countries have waived the "BUCCAL SURGERY." description in place of "ORAL SURGERY."

The new title and the thought that went into it were not chosen at random; they allow for the expansion of the field's borders and indicate the breadth of the abilities that may be learned.

As a result, we learn that the American Association of Oral and Maxillofacial Surgeons formally changed its name from the Association of Oral Surgeons years ago, with the flexibility of expanding its field of practise mentioned as the explanation for the change.

Surgical approach

The "surgery-first method" is defined as orthographic surgery followed by postoperative orthodontic therapy without preoperative orthodontic treatment. The term "modified-surgery strategy" refers to preoperative orthodontic therapy that is kept to a maximum of six months.

Virtual surgical planning

Other publications claim that the surgery-first strategy has the advantages of shortening overall treatment timeframes, favouring postoperative orthodontics, improving face aesthetics early on, and addressing OSA early on. The surgery-first strategy is usually suited for patients who do not require substantial preoperative care, such as those who have had a heart attack. well-aligned to mildly crowded anterior teeth.

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- 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 [9]. 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 [10]. 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 .

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