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Why and how maxillofacial disability and impairment due to trauma should be quantified for compensation: A need for global guidelines

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India being a country with different social, cultural, geographical and economic backgrounds; it is also grounds of rapid industrialization, mechanization of farming and increase in vehicular traffic which increases the no. of accidents and issues related to disablement and compensation of maxillofacial injuries. There is no system available nationally or globally for evaluation for maxillofacial injuries. The pathological condition states the nature of an illness but not the extent of the remaining health. Since the individual reacts as an integer, it is important to include some appraisal of the physical factors influencing his work efficiency. As there is little clarity for disability and impairment, its separate assessment for maxillofacial injury is necessary. There are complex maxillofacial injuries that may cause impairment of sense, esthetic compromises, and functional loss. Epidemiology of craniofacial trauma approximately 50% of 12 million annual traumatic wounds treated in emergency rooms involves the head and neck. Being most common along with other injuries but is never considered for compensation. Facial region being the one that is the identity and factor that influences its social and emotional behavioral changes has not been considered. In this presentation various aspects have been addressed for estimation of compensation and disablement due to maxillofacial injuries

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Plastic operation of post-burn contracture of foot and ankle joint in children

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Scar deformities of the foot and the ankle joint represent 5 to 7% of all post-burn deformities. The dorsum of the foot and the ankle areas are injured more often. Contact with burning sandal woods typically causes these burns. 138 patients were treated at the Burn department of RCUMA and Inter-regional Burn Center in Samarkand, Uzbekistan. Long-term outcomes of the plastic surgeries performed suggest that the burn patient must be under constant observation in case of tightening scars or slow growth of the injured extremity and the development of secondary changes of bones and joints. The operations must be performed within 6-12 months after healing of burn wounds to prevent secondary changes. In the case when contracture is severe, the operation must be performed as soon as possible. During this time, continuous conservative treatment serves as necessary preoperative preparation. This treatment should be continued in the hospital setting after surgery. The results supported our classification of scar contractures of the foot and ankle joint according to anatomical localization. The method of plastic operation should be chosen according to both severity and localization of the injury, using local uninjured tissues and soft scars to make trapezoid or other shaped flaps and free grafts placed on the area of the excised scars.

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