Report of the Meeting of the Oral Surgery Club of Great Britain

Thursday 13th November – Saturday 15th November 2008

The meeting was held at the Beardmore Hotel and Conference Centre in Clyde Bank near to Glasgow.

Most members arrived in the afternoon of Thursday the 13th November and following the Annual General Meeting at 6 o'clock an informal dinner was held in the hotel facility. The new president Graham Wood who was inaugurated at the Annual General Meeting welcomed members to the Scientific meeting the following morning.

Mr Ken McKenzie, Consultant ENT Surgeon started the meeting with his talk about Head and Neck Cancer in the West of Scotland. He reported on the advancement of the Head and Neck Service within Scotland, which has a population of 5 million and has 5 Head and Neck Cancer Centres. The Scottish Executive in the late 1990s audited the Head and Neck Practice activity within Scotland and found that there are approximately 2000 patients within the 5 million population, which was reasonably static. He highlighted the huge variation in practice between the different units in Lothian and Grampian. He showed how the thyroid surgery had been brought within the remit of head and neck cancer and the institution of multi-disciplinary team meetings and teleconferencing.

Mr Mark Devlin, Consultant Maxillofacial Surgeon, talked about the new Era in Scottish Cleft management. Mark started his talk by discussing the difficulties that there were in training cleft surgeons and whether a 2 year fellowship in cleft surgical training should be based on basic training in Oral and Maxillofacial surgery, Plastic surgery, Paediatric surgery or ENT surgery. He advised us that interface training in cleft surgery is now generally accepted in the United Kingdom but not by everyone and some still supported the idea of having ad hoc training, although this may produce too few cases for the trainee.

He went on to discuss the matter of numbers for each surgeon and advised that it was accepted that between 35 to 40 new cases per year was appropriate for each surgeon but then went on to discuss the arguments of why it could not be less than this number (perhaps as few as 25). It was difficult to discuss the results for individual surgeons because some had no recorded results and was there any evidence that doing higher numbers of clefts per year improved the successful outcome. There was the additional problem of whether there were enough cases of bilateral cleft, lip and palate for surgeons to train on and he acknowledged that most surgeons really did not have enough experience in these cases before they started their definitive consultant posts. He advised us that at the end of his training he had performed 138 cases and then went on to discuss the management of secondary cleft deformities. He surmised that plastic surgery trainees would struggle with interface training because of a lack of previous experience in Orthognathic surgery, although he personally felt that some of his best training was with plastic surgeons.

He then went on to discuss the managed clinical network, which had been operating in Scotland for 10 years for clefts. He thought that this might be a good thing but then on the other hand it might not as it could lead to clinicians who did little dictating to others who did a lot. However, it was good in the fact that the outcomes could be defined and at present it had led to primary cleft, lip and palate work being carried out only in Glasgow and Edinburgh in Scotland. He felt that the future demanded that there should be developed auditable practice for each region and sub specialist clinics.

After coffee Mr Graeme Conn, Urological Surgeon gave a talk on urethral reconstruction; he outlined the common conditions, which caused obstruction of the urethra including balanitis obliterans, which was an equivalent of lichen sclerosis, pelvic injuries and hypospadias. His techniques for reconstruction of the urethra involved removing the mucosa and replacing this with non genital mucosa, usually from the buccal mucosa but otherwise from post auricular skin. He then went on to discuss management of erectile impotence with prosthetic implants, management of paraphimosis and injuries to the penis. He followed this with discussion of fourernieres gangrene, which is a necrotising fasciitis, which occurred most frequently in diabetics and required radical debridement.

After lunch our president Graham Wood described the history of the Beardmore Hospital and Hotel and Conference Centre, which was started initially as a private initiative but now had been taking into the NHS as an NHS facility.

John Paul Leach, a Consultant Neurologist, talked about facial palsy, its cause and investigations. He introduced the talk with the illustration of various famous faces, who had or been rumoured to have had a facial palsy. He described a range of causes of this debilitating condition and the features to look at during the examination of a patient with facial palsy. He discussed the course of the facial nerve, its susceptibility to viral infection because of its prolonged course through the petrous temporal bone and told us that this is one of the commonest neurological problems occurring with increasing age. He discussed the differential diagnosis, Ramsey Hunt Syndrome, neoplasia, infections of the middle ear, mastoid hemi facial spasm, demyelinating disorders and tumours at the cerebellar pontine angle. He discussed diagnostic tests, which in most cases were limited to a full blood count and ESR and blink reflex testing. He discussed the prognosis of the condition and management with Prednisolone and Acyclovir.

This lecture was followed by a talk by Stephen Morley, a Consultant Plastic Surgeon who discussed surgical techniques for treatment of facial palsy. He uses the Nottingham scale for objective assessment of the degree of facial palsy and discussed primary repair, muscle grafts and free muscle and nerve grafts, usually using the gracilis muscle and cross face nerve grafts.,

Mr Henry Palin, a barrister to the Department of Health who worked on the Bristol and Shipman cases, talked about his experiences with these public enquires, which were brought about due to public disquiet. He advised us that changes with revalidation regarding the GMC were born prior to these events. He discussed in some detail both the Bristol and the Shipman enquiry, the process that was gone through and the key recommendations.

In the last talk of the afternoon Graham Wood introduced Professor Mark Wong who is to be our host in Houston for his away meeting next year. He advised us that the meeting would be built around the Hinds Symposium, which was the largest regional meeting for Maxillofacial Surgery in South West United States of America. The symposium would be on the Friday afternoon and Saturday; there would be an Oral Surgery Club meeting on the Friday morning, social events on the Sunday. Those who wish to arrive a day earlier could play golf on the Thursday.

He indicated that the meeting would be held in the Houstonian Hotel in Houston. He advised us about social activities which could be arranged and introduced a proposed programme, which could be varied.

The accompanying persons had a very pleasant day in Glasgow, which included a visit to the Kelvingrove art gallery and museum where they also had lunch. They later returned to join the members for the last lecture.

In the evening members and partners were all transported to Mar Hall for the formal annual dinner and afterwards back to the Hotel. On Saturday a visit was arranged to visit the Auchentoshan whisky distillery where we had the opportunity to hear the history and practice of whisky distilling and have a taste. Later Graham and Lindsay entertained members at their home for lunch.