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Preface

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"I have learned over the years that when one's mind is made up, this diminishes fear."
Rosa Parks, an iconic figure in the fight against racial segregation.

The complexity of surgery has been a constant throughout the history of medicine. For example, in 1559, Henry II received a head injury during a tournament. Not knowing if surgical intervention was necessary to remove the wood splinter or if it should be left in place, Ambroise Paré[1], who is the father of modern surgery, practiced using the decapitated heads of those who had recently been condemned to death. Seeing the damage that surgery would cause the king, he then decided to not intervene. Henry II died after 10 days of immense suffering.

At present, many specialities continuously question the need to resort to therapeutic medical or surgical intervention; among these are oncology, cranial traumatology, cranial, and to a certain extent, dentofacial orthopedics.

Different criteria contribute to the complexity of an indication for orthognathic surgery. The alveolar process is a complex structure; it is difficult to precisely define the size of possible alveolar movements in an individual and to consequently identify what falls within the purview of purely orthodontic or orthodontic–surgical specialities. It is a non-vital surgery that affects a key area of the human body, which is a crossroad of numerous body systems.

Predicting how much the face will grow is a complex and imprecise science; implement- ing an orthodontic–surgical proto- col requires the work of multiple specialities and needs a perfect symbiosis between a surgeon and an orthodontist.

However, judging by the efficiency of solutions offered for craniofacial dysmorphism, orthognathic surgery has not stopped developing.

When conducting a simple bibliographic search on PubMed with *orthognathic surgery* as the keyword, one can find approximately 4,300 articles published between 1944 and 2015. The oldest one, by F.W. Merrifield[2], had already discussed a possible combination of maxillofacial surgery and orthodon-

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tics. Around 60% of these articles had been published within the last 10 years (2006–2015) while the remaining 40% were published over the first 60 years. This recent increase has been almost exponential and attests not only to its considerable development but also to the amount of interest it has generated.

At present, the sheer scale of the therapeutic, orthodontic, and surgical arsenal means that it is necessary to adopt a clear approach to the orthodontic–surgical protocol. We must have a prepared response to the orthodontic–surgical strategy:

– so that the face can be segmented to treat dysmorphism;
– so that orthodontic movements can be programmed to give sufficient scope to surgery and allow continuous dental skeletal movements;
– so that we can integrate functional and psychological care during these dental skeletal modifications.

The purpose of this issue is to reflect on this topic.

In the foreword, doctors A. Bery and Y. Soyer outline the legal aspect of the multidisciplinary care of orthodontic–surgical cases. In our daily practice, it is essential to be mindful of the different medico-legal elements that regulate our practice, particularly in orthodontic–surgical cases.

A key step in these treatments is approaching the patient. This is the first element of treatment and is discussed by Dr. M. Boukili Makhoukhi. From the beginning, the practitioner is confronted with the patient's expectations to which he/she must respond and also establish the foundations of treatment. A study based on a post-surgical satisfaction survey after orthognathic surgery provides further information on this topic.

At the crossroads of orthodontic and surgical therapeutic resources, Professor P. Bouletreau shows us the transverse maxillary dimension, which plays a significantly fundamental role in the quality and stability of results. Knowing how to incorporate the transverse dimension in the treatment plan is essential, more so as its functional importance has been proven.

The logical follow-up to this exposition, the mandibular transverse dimension and the contribution of mandibular distraction, is explained by Dr. L. Pascon. When well indicated and correctly installed, mandibular distraction has led to its further development, and it is a substantial part of the therapeutic arsenal.

Maxillomandibular asymmetry is addressed by Dr. O. Esnault, who perfectly illustrates the importance of dialogue between the orthodontist and the surgeon. The treatment of different types of asymmetry merits complete and explicit diagrammatic representation. Posture is a recent element in the treatment of orthodontic–surgical cases that has long been neglected or confined to simple observations. Dr. C. Bazert introduces us to this topic and seeks to make the practitioner focus more on this area, which will progressively result in a more coherent treatment. Increased isterest in this subject will also progressively validate the protocols, which have been empirical till date.

In concrete terms, A. Kerbrat shows us how multidisciplinary treatment is structured within the hospital service. Finally, a successive summary of the

different stages of orthodontic–surgical treatment reveals the most striking recent developments. The objective for this was to obtain a modern and systematic vision of orthodontic–surgical protocols in 2016.

In light of these different articles, we hope that through these two issues, we have given you significant information on the orthodontic–surgical care of patients. For the practitioner, obtaining a clear and complete view from the outset will indicate the patient's commitment to the treatment and result in a better treatment experience in general.

" *The beginning seems to be more than half of the whole*."
Aristotle

Happy reading.

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