sequently, mandibular setback becomes futile and glossectomy particularly debilitating.
Material and Methods: We propose an alternative surgical approach in the correction of MP based on the tongue and the place it occupies in the oral cavity, rather than conventional cephalometric angular data. We recommend that the tongue space should be imperatively preserved or even improved. To that effect, the different surgical procedures are:
- tonsillectomy, especially when voluminous, thus improving the posterior lingual space.
- jaw distraction if a lack of transversal space is observed.
- maxillo-mandibular advancement, rather than a setback.

Results: After the construction of the maxillo-mandibular block around a freed tongue, the patient often presents a maxillo-mandibular 'prognathism'. Subsequently we propose an aesthetical correction of the face in its whole, including the chin, reshaping of the nose, the zygomas and paranasal areas.
Conclusion: We therefore conclude that after several years of experience it is advisable to perform a maxillo-mandibular advancement and consequently to correct the facial structures in its entirety rather than having a mandibular setback. Therefore allowing the tongue to recover its space within the oral cavity.

P.292 Complications in orthognathic surgery

A.W. Eckert, P. Maurer, M.S. Kriwalsky, J. Schubert. *Department of Oral and Maxillofacial Plastic Surgery, Martin-Luther-University Halle-Wittenberg, Germany*

Introduction: During the last decades orthognathic surgery became an increasingly applied procedure in maxillofacial surgery. An essential aim of this elective surgery is a low intra- and post-operative complication rate and a high level of patient satisfaction. Therefore, we analysed the intra- and post-operative complications over a period of 55 years.
Material and Methods: From 1–1–1949 up to 31–12–2004 all patients who underwent orthognatic surgery because of skeletal dysgnathia were retrospectively analysed. All patients were matched with regard to diagnosis, surgical procedure as well as intra- and post-operative complications under application of the statistics programme SPSS 12.0.
Results: A total of 600 patients (353 women and 247 men) were surgically treated of which 464 patients had mandibular and 109 patients had a maxillary dysgnathia. The operation methods were: sagittal split osteotomies ($n = 429$), Le-Fort-I-Osteotmies ($n = 29$), bimaxillary corrections ($n = 35$). The intraoperative complications were: bad splits ($n = 43$, 4.1%), post-operative nerve damage (55%). However, persisting nerval dysfunctions could be detected in only 28% of the patients. Post-operative wound infections were rare (5.5%), also very rare was haemorrhage (< 4%).
Discussion: Orthognathic surgery has become a routine procedure in maxillofacial surgery. An essential post-operative complication is nerval damage although this could be reduced considerably after the introduction of rigid osteosynthesis. Bad splits can be explained by the experience of the surgeon and on the bone configuration of the patient. The bactericidical one-shot prophylaxis guarantees a low post-operative infection rate and reduces the development of bacterial resistances.

P.293 Hephatic metastasis as the first place of disemination in the oral adenoid cystic carcinoma

M. Acosta, A. García-Perla, P. Infante, L.M. Gonzalez. *Servicio de Cirugia Oral y Maxilofacial, Hospital Virgen Del Rocío, Sevilla, Spain*

Introduction: Adenoid cystic carcinomas are the 12% of the malign tumours in the salivar glands. They grow up slowly, ulcerated in the oral cavity and produce pain and, increase in size. The incidence of the systemics metastasis are between 35 and 52%; usually the lung being the first place to take them.
Material and Methods: We present a patient who was diagnosted and treated for adenoid cystic carcinoma from the minor salivar gland in retromolar zone. Before surgery treatment and radiotherapy locorregional (because to a local recurrnce), the patient was found to have a methastasis in the liver, confirmed with hephatic punch without developed metastasis in the lung.
Conclusions: Althought usually the first place for the systemic metastasis in the adenoid cystic carcinoma from the salivar glands are localizated in the lung, sometimes we can see them at the first moment in other localizations like in our patients, who had their first systemic metastasis in the liver. Somehow, when the metastasis are present, the prognostic is bad for the patients.

P.294 Surgically assisted rapid maxillary expansion (SARME) and protraction face mask for correction of class III malocclusion

A. Capote, P. Rubio-Bueno, P. Martos, J. Sastre, R. González, F.J. Díaz-González. *Department of Oral and Maxillofacial Surgery, University Hospital La Princesa, Madrid, Spain*

Aim: Severe transverse maxillary hypoplasia in adult patients can be corrected with SARME. This combined orthodontic and surgical procedure causes substantial enlargement of the maxilla that prevents relapse. Association with protraction face mask for treatment of retrusive maxilla has been little documented by the literature.
Method: A 17-year-old female with class III malocclusion was referred for orthognatic surgery. She presented maxillary hypoplasia with transversal defect and retrusive maxilla with an overjet of −3 mm. Treatment with SARME and face mask protraction was performed. After buccal mucosa incision, Le Fort I osteotomy with maxillopterygoid junction disruption and without down-fracture was executed. This allowed maxillary protraction with the face mask. An interincisal palatal osteotomy from the piriform rim to the posterior nasal spine through the buccal incision was performed for expansion with a tooth-borne appliance. Initial distraction of 2 mm was done intraoperatively. After a 5-day-latency period, palatal expansions were begun at a rate of 1 mm per day until 15 mm was reached. Face mask was worn 12 h per day until malocclusion was corrected and 2 mm of overjet was achieved.
Results: Complete maxillary expansion was reached after 15-day-distraction period and 16-week-consolidation period. Face mask was worn for 6 weeks until class I relationship was achieved. Aesthetic and good functional results were obtained with stability after 12 months follow-up period.
Conclusion: SARME is actually the good standard for severe maxillary compression in adults. Combination with protraction face mask allows correction of class III maxillary hypoplasia with low surgical morbidity and predictable results.