

TMJ Replacement audit - CRF



Patient details

NHS/CHI number

(Do not use Hospital number)

DOB

Sex

Female

Male

Presentation

Has the patient been discussed at the TMJ MDT?

Who was present at the MDT meeting?

TMJ Surgeons

Restorative dentists

Any other members (provide details below)

Specialist nurse

Orthodontists

Laterality

Left

Right

For questions related to side(s). If unilateral surgery, only answer for the side in question. Leave the other ones blank.

Main indication for TMJR

Left

Right

Degenerative joint disease

Autoimmune or connective tissue disorder

Dentofacial deformity (including microsomia, ICR)

Ankylosis

Condylar trauma (including late complications)

Tumour

Other (provide details below)

Diagnostic modalities used (excluding planning CT, if only used for design purposes)

MRI

CT

Arthroscopy

Functional outcomes - Pre-surgery scores

Pain score
(1-10)

Mouth opening
(mm)

Diet quality
(1-100)

Pre-op score /
measurement

Previous treatment

Left

Right

Previous procedure(s) on the joint?

TMJ Replacement audit - CRF



Previous treatment (Continued)

Which procedures and if applicable indicate how many open surgeries

Open surgery	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
Arthroscopy	<input type="checkbox"/>		<input type="checkbox"/>	
Arthrocentesis	<input type="checkbox"/>		<input type="checkbox"/>	

Index procedure

Date of index procedure

D	D	M	M	Y	Y
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Is this surgery a revision? Y N

If the index surgery surgery is a revision:



What was the product used? Indicate the make, the composition and when it was put in

What was the reason(s) for the revision?

Infection	<input type="checkbox"/>	Metal sensitivity	<input type="checkbox"/>	Other (provide details below)	<input type="checkbox"/>
Metalwork failure	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>		
Component failure	<input type="checkbox"/>	Component loosening	<input type="checkbox"/>		
Screw failure	<input type="checkbox"/>	Malocclusion	<input type="checkbox"/>		
Heterotopic conformation	<input type="checkbox"/>	Condyle failure (breakage)	<input type="checkbox"/>		
Suboptimal position	<input type="checkbox"/>	Fossa failure (breakage or wear)	<input type="checkbox"/>		
Bone failure	<input type="checkbox"/>				

(Back to the index procedure)

Left

Right

Type of prosthesis

Custom made	<input type="checkbox"/>	<input type="checkbox"/>
Stock	<input type="checkbox"/>	<input type="checkbox"/>

Make of prosthesis

ZB	<input type="checkbox"/>	<input type="checkbox"/>
TMJC	<input type="checkbox"/>	<input type="checkbox"/>
KLS Martin	<input type="checkbox"/>	<input type="checkbox"/>
Ortho Tin	<input type="checkbox"/>	<input type="checkbox"/>
Materialise	<input type="checkbox"/>	<input type="checkbox"/>
Other (provide details below)	<input type="checkbox"/>	<input type="checkbox"/>

TMJ Replacement audit - CRF



Index procedure (Continued)

Metal used for condyle construction

Titanium

Alloy

Other (provide details in box)

Extended implants Y N Y N

Was occlusion modified? Y N

Interval between decision to treat and date of surgery (in weeks)

Multidisciplinary management

Was TMJR part of orthognathic plan? Y N

Duration of the orthodontic treatment before surgery (in weeks)

Restorative dentistry input? Y N

Was it...?

Pre-op

Post-op

Prediction planning

What prediction planning was used? 2D

3D

(If 3D) What was used? Virtual

Models

Complications at 1-year post-surgery

Did the patient develop any complications within 1-year post-surgery? Y N

Indicate which one(s)

Left

Right

Dislocation

Implant-related infection (early, late, loss of implant)

Metalwork failure

Ear canal injury

New (non-pre-existing) permanent facial nerve paresis

Hardware loosening

Metal hypersensitivity

Heterotopic ossification

Other / None of the above

Side-specific complications

TMJ Replacement audit - CRF



Complications at 1-year post-surgery (Continued)

- Malocclusion
- Bleeding
- Other / None of the above

Non-side-specific complications

If "Permanent facial nerve paresis", indicate which branch(es) of the facial nerve was (were) permanently damaged?

- | | Left | Right |
|---------------------|--------------------------|--------------------------|
| Temporal | <input type="checkbox"/> | <input type="checkbox"/> |
| Zygomatic | <input type="checkbox"/> | <input type="checkbox"/> |
| Buccal | <input type="checkbox"/> | <input type="checkbox"/> |
| Marginal mandibular | <input type="checkbox"/> | <input type="checkbox"/> |

If "Other", provide details

Was the patient re-admitted? Y N

Did the patient return to theatre? Y N

Was the patient prescribed any postoperative adjuvant therapy? No

- | | | | |
|--------------------------------------|--|--|------------------------------------|
| Hilotherapy <input type="checkbox"/> | Orastretch <input type="checkbox"/> | Physiotherapy <input type="checkbox"/> | Botulin A <input type="checkbox"/> |
| Therabite <input type="checkbox"/> | Speech and Language input <input type="checkbox"/> | Ice pack <input type="checkbox"/> | Other <input type="checkbox"/> |

Provide details for other adjuvant therapy

Did the patient develop any significant issues postoperatively?

- None Related to hearing Dental problems

Functional outcomes at 1-year post-surgery

	Pain score (1-10)	Mouth opening (mm)	Diet quality (1-100)
Date of assessment*	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y
Pre-op score / measurement	<input type="text"/>	<input type="text"/>	<input type="text"/>

* Only enter one date if all the assessment were done at the same time.