

attitude ability. Clinical practice shows that diagnostics is disturbed in these intoxicated patients, and in most cases patient does not co-operate. Possibility for vomiting is higher, which is extremely dangerous mainly in patients immobilized with cervical collar, as well as in inadequately monitoring of those patients, therefore these traumas are potentially critical for possible severe complications. It is considered that lack of enough control on alcohol sale is the main reason for decrease the age limit for its use. In our study, the most affected age group is between 20-39 - 17 patients (65.4%). With increase in age, as a general, alcohol-related traumas (AIRT) decrease. Free access to alcohol, its low price (many people can afford it) and favourable attitude to its consummation make it a social problem. Having in mind that alcohol decreases cognitive abilities to estimate the risk, decreases the ability to make rational decision, as well as bother physical ability to leave the accident place and makes self defence difficult, the big AIRT percentage in our study is no surprise. Relation between IPV (intrapersonal violence) and AIRT in MFA is well known and our study shows a higher regularity than expected - 42%. Daily alcohol use makes the person a possible victim of a thrash. Clinical material analysis shows that these injuries are obtained most often in strikes with fists, with legs, but also in hits with blunt and sharp objects. According to many studies, face is the most preferable zone in IPI after use of alcohol, whereas most of traumas are obtained on the street in front of catering establishments [23,24]. Domestic violence after use of alcohol should not be neglected as well, but because of evasive data by the patients, the exact number cannot be determined. Our study shows that RTA caused as a result of alcohol intoxicated motor vehicle drivers are extremely severe problem. Despite efforts of various organizations in campaigns against driving in intoxicated state, RTA, caused by alcohol intoxicated motor vehicle drivers take a major part of MFA traumas - 5.7%, according to our study. Regardless of the fact that many campaigns are performed for prevention of motor vehicle driving by intoxicated drivers, as well as for introduction of more strict sanctions for such drivers, success in this direction is not very encouraging.

4. Conclusion

Clinical material analysis in our study is thoroughly performed in conformity with tasks and goal determined and gives us a reason to conclude that combined maxillofacial traumas are frequently observed health problem in contemporary society and sometimes these may complicate work in many maxillofacial surgery wards. We determined that CMFT represent 36,6% of all maxillofacial traumas and we emphasize the necessity of early interdisciplinary approach in diagnostics and preparation of therapeutic plan for these traumas.

Acronyms Used

ALRT- alcohol related trauma
 CMFT- combined maxillofacial trauma
 RTA- road traffic accident
 MFA-maxillofacial area
 CrT- cranial trauma

References

- [1] Perry, M. Maxillofacial trauma. Developments, innovations and controversies Injury. Int. J. Care Injured 2009, 40, 1252-1259.
- [2] Perry, M. Advanced Trauma Life Support (ATLS) and facial trauma: can one size fit all? Part 1: Dilemmas in the management of the multiply injured patient with coexisting facial injuries. Int. J. Oral Maxillofac. Surg., 2008; 37:209-214.
- [3] Perry, M., C. Morris: Advanced Trauma Life Support (ATLS) and facial trauma: can one size fit all? Pa Part 2: ATLS, maxillofacial injuries and airway management dilemmas Int. J. Oral Maxillofac. Surg., 2008, 37: 309-320.
- [4] Thoren, H., J. Snall, J. Salo, L. Suominen-Taipale, E. Kormi, C. Lindqvist, J. Tornwall. Incidence and Types of Associated Injuries in Patients With Fractures of the Facial Bones 2010. American Association of Oral and Maxillofacial Surgeons. J. Oral Maxillofac. Surg., 2010, 68: 805-810.
- [5] Bryan, Bell, R. The Role of Oral and Maxillofacial Surgery in the Trauma Care Center J. Oral Maxillofac. Surg., 2007, 65: 2544-2553.
- [6] Down, K. E., D. A. Boot, D. F. Gorman: Maxillofacial and associated injuries in severely traumatized patients: Implications of a regional survey. Int. J. Oral Maxillofac. Surg., 1995, 24: 409-412
- [7] Gassner, R., T. Tuli, O. Hachl, A. Rudisch, H Ulmer Cranio-maxillofacial trauma: a 10 year review of 9534 cases with 21 067 injuries. J. Cranio-Maxillofacial Surg., 2003, 31, 51-61.
- [8] Davidoff, G., M. Jakubowski, D. Thomas. The spectrum of closed head injuries in facial trauma victims: incidence and impact. Ann. Emerg. Med., 1988, 17: 6-9.
- [9] Gwyn, P. P., J. H. Carraway, C. E. Horton. Facial fracture - associated injuries and complication. Plast. Reconstr. Surg., 1971, 47: 225-230.
- [10] Oller, D. W., J. W. Meredith, R. Rutledge, M. Thomason, T. Clancy, J. Moylan, B. Foil. The relationship between face or skull fractures and cervical spine and spinal cord injuries: a review of 13 834 patients. Accid. Anal. Prev., 1992, 24: 187-192
- [11] Ardekian, L., D. Rosen, Y. Klein, M. Peled, M. Michaelson, D. Laufer. Life threatening complications and irreversible damage following maxillofacial trauma. Injury, 1998, 29: 253-256.
- [12] Davidson, J. S., D. C. Birdsell. Cervical spine injuries in patients with facial skeletal trauma. J. Trauma, 1989, 29: 1276-1278.
- [13] Rocca, F., E. Cassarino, R. Boccaletti. Cervical spine fractures associated with maxillofacial trauma: An 11-year review. J. Craniofac. Surg., 2007, 18: 1259.
- [14] Merritt, R. M., M. F. Williams. Cervical injury complicating facial trauma: incidence and management. Am. J. Otolaryngol., 1997, 18: 235-238.
- [15] Elahi, M. M., M. S. Brar, N. Ahmed. Cervical spine injury in association with craniomaxillofacial fractures. Plast. Reconstr. Surg., 2008, 121: 201.

- [16] Hackl, W., C. Fink, K. Hausberger. The incidence of combined facial and cervical spine injuries. *J. Trauma*, 2001, 50: 41.
- [17] Hackl, W., K. Hausberger, R. Sailer. Prevalence of cervical spine injuries in patients with facial trauma. *Oral Surg. Oral Med. Oral Pathol. Oral Radiol. Endod.*, 2001, 92: 370.
- [18] Ardekian, L., D. Rosen, Y. Klein, M. Peled, M. Michaelson, D. Laufer. Life threatening complications and irreversible damage following maxillofacial trauma. *Injury*, 1998, 29: 253-256.
- [19] Gossman, M. D., D. M. Roberts, C. Barr. Ophthalmic aspects of orbital injury: a comprehensive diagnostic and management approach. *Clin. Plast. Surg.*, 1992, 19: 71-83.
- [20] Al-Qurany, I. A., L. F. Stassen, G. N. Dutton, K. F. Moos, A. el Attar. The characteristics of midfacial fractures and the association with ocular injury: a prospective study. *Br. J. Oral Maxillofac. Surg.*, 1991, 29: 291-301.
- [21] Haug, R. H., J. Prather, A. TIndresano. An epidemiologic Survey of facial fractures and concomitant injuries. *Journal of Oral and Maxillofacial Surgery*, 1990, 48: 926-932.
- [22] Vetter, J. D., R. G. Topazian, M. H. Goldberg et al. Facial fractures occurring in a medium-sized metropolitan area: recent trends. *Int. J. Oral Maxillofacial. Surg.*, 1991, 20: 214-216.
- [23] Laverick, S., N. Patel , D. C. Jones. Maxillofacial trauma and the role of alcohol. *British Journal of Oral and Maxillofacial Surgery*, 2008, 46: 542-546.
- [24] Warburton, A. L., J. P. Shepherd. Alcohol-related violence and the role of oral and maxillofacial surgeons in multiagency prevention. *Int. J. Oral Maxillofac. Surg.*, 2002 Nov., 31: 657-663