



LITHUANIAN UNIVERSITY OF HEALTH SCIENCES
MEDICAL ACADEMY
FACULTY OF ODONTOLOGY
CLINIC OF MAXILLOFACIAL SURGERY

**Preparation and writing of an oral and maxillofacial surgery patient's academic
medical history**

Methodological manual

Kaunas, 2023

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SUMMARY

The academic medical history (AMH) of an oral and maxillofacial surgery patient is the constituent of the integrated study programme of Odontology of the Faculty of Odontology of the Lithuanian University of Health Sciences Medical Academy (LSMU MA). The AMH manual is intended for fourth and fifth year students of the Faculty of Odontology. The AMH preparation aims to develop students' clinical and research skills. This methodological manual is an official document of LSMU MA Faculty of Odontology which defines the guidelines for the AMH, the format of the written medical history, the assessment procedures, and deadlines. A medical history is a document where such things as the patient's disease onset, development, effectiveness, and outcome of treatment are registered. This document includes not only the medical information, but also some personal data. A case study medical history is the most suitable simulation for a doctor to practice, which allows investigating the disease by direct communication and observation of patient's treatment and the course of disease.

THE PURPOSE OF THE ACADEMIC MEDICAL HISTORY

The AMH must show in a summarised form:

1. the general level of the student's theoretical knowledge, meaning, analytical and critical thinking and subject erudition;
2. the ability to diagnose the disease and plan treatment;
3. the ability to independently apply theoretical knowledge in practice;

4. the ability to independently collect data for a written medical history, it includes an anamnesis, test results, the treatment plan, prevention means of complications and the prognosis of treatment effectiveness;
5. The ability to use not only the fundamental knowledge acquired during studies, but also demonstrate the ability to gather the newest information from contemporary data bases of scientific literature.

PATIENT ASSIGNMENT AND ACADEMIC MEDICAL HISTORY WRITING

The teacher teaching the subject refers the student to a patient who is being treated at the Clinic of Maxillofacial Surgery. Students can choose the patient themselves but must agree with the teacher and get his approval. The pathology of the selected patient must be relevant to the scope of the student's curriculum. Independent medical history writing is a good way to demonstrate the acquired knowledge and its practical application. The following requirements must be met when writing an AMH:

1. AMH should strictly conform to the form accepted at the Maxillofacial surgery clinic of Faculty of Odontology of the Lithuanian University of Health Sciences Medical Academy (LSMU MA);
2. presentation of the clinical data must be accurate, logical, clear and consistent;
3. test results are given comprehensively with interpretation;
4. when describing separate parts of the medical history, the student must demonstrate not only the fundamental knowledge acquired during his studies, but also use the latest information from modern databases of scientific literature and show his erudition;
5. The ALI starts to be written at the beginning of the semester and is submitted at the time set by the teacher, otherwise the evaluation score may be reduced;
6. the same case histories, signed by different curators are not accepted (if one patient is supervised by two or more students, only the anamnesis and examination data can coincide; besides, the sequence of presentation does not have to be the same);
7. a student who has obtained the negative evaluation for case history, must rewrite it based on the teacher's comments;
8. a student is not allowed to take the final module control test, if case history was chosen as independent work and was not submitted, or if the negative evaluation was obtained.

STRUCTURE OF THE ACADEMIC MEDICAL HISTORY

The AMH consists of a following parts:

- I. Documental part
- II. Complaints
- III. History of the disease (anamnesis morbi)
- IV. Life history (anamnesis vitae, allergica et laboris)
- V. The present condition of the patient (status praesens objectivus)
- VI. Objective examination and condition of the face and jaws (Status specialis)
- VII. Preliminary diagnosis
- VIII. Clinical examination plan
- IX. Differential and clinical diagnosis
- X. Treatment
- XI. Pre- and postoperative diary
- XII. Epicrisis and prognosis
- XIII. List of references

I. DOCUMENTAL PART

1. Patient's full name
2. Patient's age
3. Residential address
4. Workplace, profession and position
5. Institution and specialist who referred the patient
6. Diagnosis on admission
7. Date of admission to the clinic
8. Diagnosis on admission
9. Clinical diagnosis

10. Final diagnosis

Date of its establishment

- a) Main disease
- b) Main disease complications
- c) Comorbidities

11. Discharge date

12. Operations

- a) Operation's title
- b) Type of anaesthesia
- c) Intraoperative complications

13. Outcome of the disease

- a) Recovered
- b) Condition has improved
- c) Without changes
- d) Died

After the documentary part, a short summary is written, where you need to pay attention to the diagnosis of the referral and which specialist determined it. Possible reasons for the discrepancy in diagnosis should be discussed. It's important pay attention to the time of hospitalization and the time since the onset of the disease, analyse the reasons for this duration, the possible consequences of the spread of the disease and the influence on treatment tactics. The diagnosis during hospitalization of the patient is made in the outpatient clinic or in the emergency department. Their must match the diagnoses given in the original medical history. It's important pay attention to whether these diagnoses coincide. If they do not match, it is necessary to discuss possible reasons for the discrepancy. All diagnoses are written in Latin. Clinical diagnosis is established upon admission to the hospital on the same day or for a period of three days if an additional one is required examination of the patient. The final diagnosis can be made after surgery or even on the day of discharge. It is important to properly discover the causal relationship between underlying diseases, complications and co-morbidities, so they must be properly assigned to these categories.

II. COMPLAINTS

When evaluating the patient's complaints, special attention should be paid to the nature and variability of the manifested symptoms. First of all, it is necessary to list the main symptoms and evaluate their pathognomonic nature. Later, less important, secondary complaints can be listed. Complaints must be described as precisely as possible: location, nature, intensity, duration, periodicity of the indicated symptoms (say, pain). It is important to find out the cause of the onset of symptoms, which is indicated by the patient, changes in symptoms (complaints) after previously applied treatment, other applied measures or environmental factors (temperature, body position, etc.). A detailed analysis of the symptoms should be described. Accurately assessed complaints and their proper interpretation can be the main signs of some diseases.

III. HISTORY OF THE DISEASE (ANAMNESIS MORBI)

This part must reflect the change in the main symptoms, the onset of the disease, the course from the onset of the first symptoms until hospitalization. The patient can name the most important symptoms, which seem to him to be the main ones, but the doctor must see the beginning of the disease as early as possible and correctly interpret its onset and dynamics. It is very important to distinguish the causative, predisposing, causal factors of the disease, that had an influence on the concealment or manifestation of symptoms, and that determined the course of the disease. In order to correctly interpret the diagnosis, it is very important to take into account the functional disorders (swallowing, chewing, occlusion, muscle dysfunction or sensory disorders) that have occurred and become evident. It is important to find out whether the patient self-medicated or whether the treatment was prescribed by a doctor. How did these measures work, what was their influence on the course of the disease, what was the effectiveness of this treatment.

A certain category of patients are traumatized people. It is necessary to describe the condition of the patient at the time of the injury (was there any pathology at the site of the injury before the injury). It is important to indicate the time, place, reasons, and circumstances of the injury, who provided first aid, when and what. It is necessary to describe the additional symptoms that are often found in trauma to the face and jaws; damage to the brain (loss of consciousness, nausea, vomiting, etc.), injuries to the

eyes or other parts of the body. At the time of the injury, it is very important to find out whether there was intoxication with alcohol or other substances.

When collecting the anamnesis, it is necessary to find out whether the existing changes are related to the general condition of the body, concomitant diseases, and the drugs used. It is important to relate the symptoms and course of the main disease to general health and its changes (changes in hearing, vision, appetite, weight).

IV. LIFE HISTORY (ANAMNESIS VITAE)

It is necessary to find out living and working conditions, family situation, bad habits, allergic anamnesis. Pay attention to the facts that may influence the occurrence, spread and course of the disease. Sometimes it is very important to find out whether the patient has had contact with domestic or wild animals or has not been bitten by insects or other animals. In the anamnesis of life, it is necessary to pay attention to the connection between the causes of the appearance of the disease with the patient's hobbies, trips to exotic countries, eating habits and other important aspects that could have led to the onset of the disease. It is very important to find out the anamnesis not only of the person, but also of the family and kindred, where it is possible to discover data showing a connection with the heredity of the disease or a tendency to suffer from certain diseases. It is necessary to collect information about the health status of relatives and relatives, the illnesses of the mother and father, the course of the mother's pregnancy and childbirth. Such attention should be paid to patients with congenital diseases or abnormal, oncological, and other diseases, the occurrence of which may have been influenced by heredity. This section must describe all the patient's illnesses, contact with people suffering from infectious diseases (for example, tuberculosis, sexually transmitted diseases, etc.). When collecting the patient's anamnesis, it is important to find out previous pregnancies, deliveries, terminations of pregnancy, and the regularity of menstruation.

Allergic anamnesis is very important. Therefore, it is necessary to find out if the patient is allergic to something, what allergens have caused previous reactions, how they appeared, how they were treated, and how effective the treatment was. It is necessary to pay attention to all allergens that can cause a reaction (food products, drugs, fragrances, animals, metals, physical factors (cold, sunlight, etc.)). Relevant information is about the seasonality, periodicity, severity, and clinical signs of allergic reactions.

When collecting the work anamnesis, it is important to find out whether professional and work environment factors could have influenced the illness or injury. It is very important to know how long and for what reasons in the last 12 months the patient had a certificate of incapacity for work. If the patient has a disability, it is important to find out when he acquired it and what are the causes of the disability. In the anamnesis, it is necessary to indicate the state of the person's social insurance.

V. THE PRESENT CONDITION OF THE PATIENT (STATUS PRAESENS OBJECTIVUS)

The general condition of the patient is assessed taking into account his general appearance, consciousness, body temperature and vital processes - pulse, arterial blood pressure and respiratory rate. The general condition of the patient may be: good, satisfactory, hard and very hard. Good condition - the patient is conscious, feels good, does not complain about anything, vital processes are normal. Satisfactory condition - the patient complains, but the vital processes are normal. Serious condition - vital processes are abnormal and unstable, but the patient is conscious. A very serious condition - vital processes are abnormal and unstable, consciousness is impaired.

Describes the position of the patient, which can be active free or active compulsory and passive. Posture can be relaxed or sluggish. Body composition is determined empirically, it can be normosthenic, hypersthenic or asthenic.

When examining the skin surface of the body, skin colour, moisture, rashes, scars, and skin lesions are taken into account. Hair and nails are described. When examining the subcutaneous tissue, attention should be paid to possible swelling (oedema). Anthropometric data are also important: height, body mass, chest circumference, dynamometric measurements (muscle strength).

It is very important to properly assess the body temperature, which is divided into hypothermia and hyperthermia. You need to know not only the current body temperature, but also the dynamics of its changes. There are eight fever types: continuous, fluctuating, intermittent, reversible, fluctuating, debilitating, inverse (syn. inverse), irregular.

When examining the respiratory system, it is important to find out if there is cough, sputum, coughing up blood, chest pain when breathing, shortness of breath, wheezing in the chest and obstructive breathing (stridor). Respiratory rate is assessed. During auscultation, it is important to note: whether breathing is bronchial or vesicular, whether breathing is not heard at all, what is the frequency of breathing.

When describing the cardiovascular system, it is important to count the heart rate per minute, rhythmicity, possible extraneous sounds (murmurs, arrhythmia, additional sounds). It is necessary to measure arterial

blood pressure. When palpating the pulse, its frequency is counted, and the filling of the vein is assessed.

When evaluating the digestive system, it is important to find out whether there are pains in the epigastrium and abdomen when palpating, whether defecation is regular, stools are normal.

Examination of the urinary and genital (syn. urogenital) system is determined by making sure that urination is regular and there are no signs of urinary retention. Possible swelling of the face may reflect signs of kidney failure. Renal insufficiency is very important for drug dosing. It is important to find out whether women have regular menstrual cycles or are not currently menstruating because they are planned operations should be postponed during them.

It is important to find out about all chronic and acute diseases that have recently occurred. In the case of chronic diseases, it is necessary to assess how widespread they are, what medical treatment is applied, and whether they are properly managed. Some drugs (antiplatelet agents, anticoagulants, antidepressants and many other drugs used to treat chronic diseases) can have a negative effect on the treatment of the underlying disease.

VI. OBJECTIVE EXAMINATION AND CONDITION OF THE FACE AND JAWS (Status specialis)

This is one of the most important sections of medical history. It describes the condition of the face and jaws during hospitalization. Based on these data, a patient's follow-up plan is drawn up, a preliminary or clinical diagnosis is made, and treatment is prescribed. This section describes in detail the data of inspection, palpation, evaluation of functional disorders. The special examination of the face and jaws consists of two main parts: an examination of the face and neck and an examination of the mouth.

Examination of the face and neck area

1. Facial examination: expression, symmetry, hair type, skin colour, shape of neck, nose, lips, cheeks, chin. Observe and describe skin and subcutaneous changes: swelling, oedema, infiltration, haemorrhages, changes in skin pigmentation, inflammatory and neoplastic changes, ulcers, wounds, scars. Investigate and describe functional disorders in the face: sensory disorders of the facial skin, their symmetry, function of facial expressions and masticatory muscles.

When examining the function of facial muscles, the muscles of the forehead, eye-closing, and mouth area are evaluated, the patient is asked to perform various facial expressions in order to assess the muscle function and its symmetry. Masticatory muscle function is assessed by asking the patient to open and close the mouth. The movement is observed, and the range of mouth opening is recorded (the norm is 4-5 cm between the antagonists' teeth), possible deviations of the movement, joint movement is examined during opening and closing mouth, attention is paid to the sounds caused by the joint movement. It is important to assess visual function: eye position symmetry, eyeball movements, primary vision disorders (impaired vision, diplopia, blindness). The mucous membrane of the lips is carefully examined, and the observed changes are carefully described.

In trauma patients, facial asymmetry, haematomas, their location and size should be assessed. Pay attention to current or past signs of bleeding from the mouth, nose, ears. If cerebrospinal fluid leak is suspected, the data determined by the tests are described. If a patient with wounds is admitted to the hospital, they are described - their nature, size, depth, injuries to other organs in the wound are indicated. If a patient arrives with repaired wounds, describe the condition of the wound, the method of suturing (or other method of tissue joining), bleeding or secretion from the wound.

2. Palpation: the area of the face and jaws is palpated with both hands, moving from the healthy area towards the affected area. When palpating, an effort is made to determine and describe the location, size, shape, boundaries, consistency, pain, mobility, fluctuation (accumulation of fluid in the tissues), surface, whether the process is damaged, involving the skin and subcutaneous tissue, muscles, salivary glands, bone. Frontal lymph nodes are easier to feel when the patient relaxes the neck muscles and tilts the head down (toward). The condition of regional lymph nodes is determined - mobility, pain, size, consistency. It is important to find out if certain lymph nodes are enlarged or if they are stuck to each other in conglomerates. When palpating symmetrically with both hands, the movements of the articular head are palpated. Symmetry of joint movements, painfulness are evaluated, in injured patients it is determined whether there are movements of the articular head. Palpation is performed in the tragus area with the little fingers placed in the listening hole.

Palpation of the skin of the face looks for painful or pain evoking areas. The tactile sensations of the skin, the soreness of the exit openings of the trigeminal nerve are determined with the fingers, the sensitivity of the skin to pain is examined with a sharp needle, the symmetry of sensations on both sides in the innervation zones of all three branches of the trigeminal nerve is compared.

Oral examination

Instruments used for this examination: dentist's mirror, spatula, tweezers, and probe. A mirror illuminates or examines a hard-to-see area, soft tissues are pressed or pulled away with a spatula, tooth tissues are examined with a probe, tooth mobility is examined with tweezers.

The examination starts from the vestibule of the mouth. It is important to study and describe the colour, consistency, integrity, surface features of the oral mucosa. Examining the salivary gland ducts, their openings, by massaging the glands with the other hand, it is determined what saliva or secretions flow through the opening of the duct. Saliva can be clear, thick, cloudy, purulent. Sometimes saliva may not exude at all due to a stone in the duct or a malfunction of the gland. The buccal and sublingual salivary glands are easier to feel with both hands (bimanually). In the mouth, the salivary glands and ducts are palpated with the index finger, and from the frontal side, the soft tissues are pressed with the other hand to raise the floor of the mouth and the organs in it (salivary glands and lymph nodes). Attempts are made to palpate the ducts all the way to the ampullary part. Infiltration of ducts, possible foreign bodies in them, their position are evaluated. In this way, the salivary gland can also be felt, its size, consistency, soreness, mobility, and surface relief are determined. The hard, soft, palate, lingual, molar (syn. retromolar), paratonsillar, pharyngeal (syn. retropharyngeal) areas are inspected and palpated. The tongue is described: its shape, size, surface, plaque, dryness, its movements, and sensations are evaluated.

When examining with both hands, pathological movements of the lower jaw are determined: thumbs are placed on the alveolar processes or teeth of the mandible, and an attempt is made to assess with fingers from the submandibular side bone integrity. The bony fragments are moved in opposite directions and this way their mobility is determined.

Later, the type of occlusion should be determined, i.e. ratio of lower and upper teeth: normal orthognathic or pathological (according to Angle's classification), or by synonyms - prognathia, progenia, open, deep, cross, as well as to identify anomalies and deformations of the lower and upper

jaws. Further examine and describe the condition of the teeth, assess the mobility of the teeth, determine whether there is dental plaque. To determine the sensitivity of teeth to percussion, biting, chemical and thermal stimuli. Describe the condition of the gums: changes in the gingival papillae, the depth of the gum pockets and their contents. At the end of the description of this part, write a dental formula, in which the identified pathological changes of the teeth are marked with conventional signs.

Formula for permanent teeth

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Formula for deciduous dentition

55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75

This section must be written especially carefully: it is necessary to present the maximum number of symptoms, to note their dynamics (describe the important symptoms, indicate the date or even the time when they appeared).

VII. PRELIMINARY DIAGNOSIS

It is written based on the patient's complaints, the course of the onset and spread of the disease, and objective research data. When writing the justification of the preliminary diagnosis, it is important to name the most important data of the anamnesis and the most characteristic symptoms, to set out a targeted analysis that forms the prerequisites for establishing this diagnosis. Finally, a preliminary diagnosis is formulated, which is written in Latin.

For example: Preliminary diagnosis: Fractura mandibulae in regio anguli dextri.

VIII. CLINICAL EXAMINATION PLAN

All planned clinical examinations must be justified. It is necessary to specify the purpose for which they will be performed. A bad example is "A general blood test is performed to assess the general condition of the body." It is important to indicate, what examination indicator is relevant and what is its significance for the examination. It is decided whether the consultations of other specialists will be necessary. Not only the specialist is indicated, but also the purpose for which he is called.

It is necessary to justify the necessity of the examinations planned to be carried out in a specific case and, based on the data of the latest literature, additionally indicate the possible examinations to be carried out.

The following tests are most often performed:

1. General and biochemical blood tests.
2. Urine test.
3. Electrocardiographic examination.
4. Electrometric examination (dental pulp sensitivity to variable current).
5. Radiological examinations:
 - a) radiographs of teeth;
 - b) orthopantomograms;
 - c) overview, specific and other radiographs of the head;
 - d) computed tomography (with or without contrast);
 - e) magnetic resonance imaging;
 - f) ultrasound examination, etc.
6. Microbiological tests from wound, pus, blood, urine etc. Microflora and antibioticogram are determined.
7. Morphological tests of tissues (cytological and histological tests).

Next, all research data, their evaluation and interpretation, the conclusions of specialist consultations are written down, their significance and influence on the further examination and treatment of the patient are described.

IX. DIFFERENTIAL AND CLINICAL DIAGNOSIS

The established diagnosis must be distinguished from other diseases with similar symptoms. Therefore, when writing a differential diagnosis, it is important to describe as many pathologies as possible, the symptoms of which may be similar. The differential diagnosis should be written using the literature, the sources of which are indicated at the end of the work (or in the last chapter of the work). Appropriate sources in this section are textbooks, monographs, educational books, scientific articles. Lecture materials, synopses, journalistic, science popularization and other similar sources cannot be indicated as a source.

When writing this part, it is necessary to differentiate the diagnosis, certain symptoms or their complexes, to assess the generality of the symptoms, the consistency of occurrence. Complaints, the course of the disease, the results of clinical and special tests and the conclusions of specialist consultations are evaluated.

After performing the differential diagnosis, a clinical diagnosis is written, which may not coincide with the referral, hospitalization or preliminary diagnosis. Therefore, when writing the justification of the clinical diagnosis, it is necessary to mention what symptoms or test results led to the discrepancy in the diagnosis. It is very important to note in the background what external (cold, trauma...) or internal factors (age, physiological conditions, concomitant diseases...) influenced the onset and course of the disease.

A clinical diagnosis can be considered a final diagnosis if it does not change or is not supplemented by other important data after treatment or surgery. When writing a clinical diagnosis, the main disease, complications and concomitant diseases are indicated. It is necessary to indicate the date of clinical diagnosis. If necessary, it is necessary to indicate the spread of the disease, stage, clinical group and other additional data. The diagnosis is written in Latin language.

For example: **Clinical diagnosis** (the date of its establishment)

Main disease: Neuralgia nervi trigemini dextri, rami secundi. Origo ignota. Periodus subacutus. Forma mediocris. Stadium secundum.

Complications: Haematoma suppurativa in regio infraorbitalis dextri. Trombophlebitis vena faciei lateris dextri.

Comorbidities: Diabetes mellitus. Typus secundus. Ulcus trophicus cruris dextri.

X. TREATMENT

When writing a treatment, the first step is to create a treatment plan. A treatment plan is written based on a literature review. This plan may not match the patient's actual treatment plan. In this case, your proposed treatment plan should be accompanied by a brief description of the treatment plan used in the Maxillofacial Surgery Department and a detailed analysis of the validity of the differences. The student must explain in a reasoned manner which moments or stages of the applied treatment, in his opinion, could be changed or alternative. It is necessary to clearly articulate the advantage of the plan you present, based on the information used in the scientific articles. This section must use sources found in scientific information databases.

The selected conservative and operative treatment are described in detail. Indications for conservative treatment, effectiveness of treatment, indications for each prescribed drug are indicated. It is necessary to write prescriptions for all the medicines used by the patient. Inpatient pain relievers (premedication, postoperative pain management) used before and during or after surgery should be described. It is also necessary to describe the antibacterial drugs and local anaesthetics used during the operation.

There is no need to describe the drugs that the anaesthesiologist prescribes to induce anaesthesia or narcosis. When surgical treatment is applied or recommended, a surgical protocol must be written. The protocol consists of the following parts:

Operation protocol

1. Name, surname, age of the patient.
2. Diagnosis before surgery (main disease, complications, comorbidities).
3. Anticipated operation.
4. Indications for surgery.
5. Date and duration of the operation.
6. Method of anaesthesia.
7. Description of the operation (detailed description).
8. Achieved results.
9. Diagnosis after surgery (if the diagnosis did not change after surgery, it can be noted that the diagnosis is the same).

XII. EPICRISIS AND PROGNOSIS

Epicrisis - the concluding part of a medical history explaining the cause, course, treatment and outcome of a disease or a critical evaluation of all clinical and laboratory data about the course of this disease. In epicrisis, the final diagnosis is formulated and written.

The characteristics of the course of the disease, the tests performed, the treatment, its results and complications are briefly described. The condition of the patient at the time of discharge is noted, the advice given when the patient leaves, the drugs that are advised to be used on an outpatient basis (dosage, frequency, and time of use) are indicated. Referrals to the dentist and/or family doctor are provided). Recommendations are given on how to care for the wound, how often to apply the bandage, and when to remove it. It should be specified suggestions for which drugs to prescribe for outpatient use. The patient's incapacity for work, the duration of the incapacity for work and the number of the incapacity for work certificate, the continuation of the incapacity for work certificate and recommendations for physical exertion are noted. It is necessary to write what additional tests or procedures are required, what specialists (rehabilitator, dentist, neurologist, ophthalmologist) consultation or supervision is required during outpatient treatment.

Prognosis is a prediction of the development or outcome of a disease. The prognosis can be: good or favourable for recovery (prognosis bona), bad (prognosis mala), very bad (prognosis pessima), ungrateful (prognosis infausta), doubtful (prognosis dupia), unreliable (increata). It is necessary to note from what point of view the prognosis is made: in terms of life (prognosis quo ad vitam), complete recovery (prognosis quo ad valitudinem completam), functional recovery (prognosis quo ad functionem).

It is necessary to provide a forecast of work capacity (ability to do usual job completely, partially, job profile needs to be changed).

XIII LIST OF REFERENCES

All literature sources to be used in writing the medical history are listed, in compliance with the requirements for compiling literature lists.

GENERAL METHODOLOGICAL REQUIREMENTS

Scope of work. The recommended length of the work is at least 10-15 pages (starting with the introduction and ending with the epicrisis), but it is not strictly regulated, as the specifics of the disease must be taken into account.

Text requirements. The works are printed on a computer (28-30 lines per page), on one side of A4 format, white sheet. Margins are left: 20 mm at the top and bottom, 30 mm at the left and 10 mm at the right. Printed in size 12 Times New Roman font. Special characters or characters that cannot be printed on a computer are entered by hand. The work is printed at 1.5 line spacing.

Page numbering. The pages of the work must be numbered, starting from the title page (the page numbers of the title page, summary and content are not written on it). Pages are marked with Arabic numerals in the lower right corner of the page.

Binding. Reports are bound so that the title page is visible.

Language. The work must be written in the correct English UK language.

Spelling and punctuation. The report must meet the current English UK spelling and punctuation requirements. Foreign nouns are written in the original language according to the norms established by the Lithuanian Language Commission. Russian surnames are written in Latin characters without a patronymic.

Citations. References to scientific literature publications cited in the text (number in the bibliography) are enclosed in square brackets, for example: [12]. Verbatim quotes are written in quotation marks, for example, „computer“. Texts must be quoted in strict accordance with the source cited. Even obvious typographical errors in the cited source cannot be corrected. Cited sources and authors are indicated in the text. When quoting several authors, the name of the first author is written, with the suffix “and others” or “with co-authors”, and the number of the cited source is indicated in square brackets. The full bibliographic description of the cited source is provided in the bibliography. If the cited work is not written in Latin letters, the references need to be transliterated, for example, by Lukov et al. [19].

Plagiarism. Plagiarism is considered one of the biggest misdemeanours in the academic community and is seen as cheating. Plagiarism can be defined as the presentation of the work of strangers or other authors as their own. It is important to remember that a report (like any other academic text) is an

author's work, so anything that is not in quotes or references is considered the student's original thoughts and words. There are three ways to use another author's thoughts in your text: an exact quote, a paraphrase, and a summary. In the case of an exact quotation, the author's idea is rewritten in quotation marks word for word, without changing anything, and the source of the quotation is indicated, giving the number of the page (s). In the case of summarisation and paraphrasing, the text is summarised and reworded in author's of the report own words, without changing the content and leaving the terms. Paraphrasing differs from a summary in that in the case of a summary, the main idea of the author is brought forward and the details are given afterwards; paraphrasing does not change the course of text argumentation. In all three cases, it must be clear where the thoughts of the other author begin and end. The following statements are used to define the beginning: "As suggested by X", "As X points out", "According to X" etc., and the reference marks the end of other authors' thoughts. Plagiarism is possible even if the thoughts of other authors are incorrectly or insufficiently paraphrased and despite the fact that the original source is cited. In other words, even if there is an author and page in parentheses at the end of the sentence, but the retrieved sentence is changed only minimally (by replacing two or three words); such a case will also be considered plagiarism. Therefore, it is best either to retell the idea in your own words so that the whole sentence structure and most of the words are changed, or to quote the sentence / paragraph. Plagiarism is considered to be a place in a report where the thoughts of a published or unpublished author's work are rewritten without quoting; paraphrased or summarised thoughts from the published or unpublished author's work, research or lecture material, without reference to the source; a table, graph or chart, in whole or in part, without reference to the source. The text of other authors may not exceed 20 percent of the report.

Footnotes. Footnotes are for comments. They must be numbered in the submitted work. Printed in size 10 font, 1.5 line spacing.

Tables. The tables are numbered in Arabic numerals throughout the work in sequence. The title is written above the table, on the left edge. The word "Table" and its number are written in size 12 bold font. Explanations are written below the table. Each column must have a name. A new table row must be created for each row. There should not be more tables than text. Where necessary, they should be further clarified. When the table is mentioned in the text, its number is indicated. If they are taken from other publications, indicate the source and author. Example table:

Table 2. Description of patients

		Placebo	Treatment with medications	P
Sex (M/F)		7/5	7/5	
Age (years)	31-40	0	2	$\chi^2 = 6.8;$ $df = 5;$ $P = 0.238^b$
	41-50	0	2	
	51-60	5	5	
	61-70	2	2	
	71-80	4	1	
	81-90	1	0	
Average age (SD)		65.9 (10.8)	54.9 (11.5)	0.077 ^b
Number of neutrophils ^a , average (SD)		3.94 (1.37)	3.61 (2.15)	0.48 ^b

^bStatistically non-significant when $P < 0.05$ (MonteCarlo test).

SD = standard deviation; χ^2 = Chi-Square test.

^bStatistically unreliable when $P < 0.05$ (MonteCarlo test). SN = Standard deviation; χ^2 = Chi-Square test.

Figures (illustrations, diagrams, diagrams, graphs). Figures are numbered consecutively in Arabic numerals. The number of the figure, the abbreviation of the word “fig.” and the title are written at the bottom, starting from the left edge in bold size 12 font.

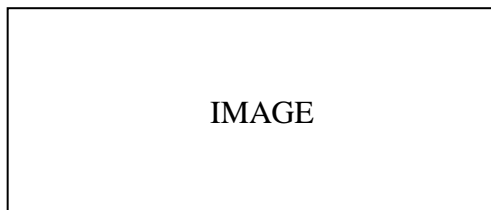


Figure 1. Figure title.

There should be no more figures or illustrations than text; if necessary, the figures and illustrations must be further explained, printed in high quality, marked with a number. If figures are taken from other publications, indicate the source and author.

Abbreviations, symbols and nomenclature. The symbol % must be used to indicate percentages, h - hours, min - minutes, s - seconds. *In vitro*, *in vivo*, *in situ* and other Latin expressions must be written in italics. Only standard abbreviations are used. All units must be marked in metric system. Abbreviations in the title are avoided. When the abbreviation is mentioned for the first time in the text, its full title must be written, with the abbreviation in brackets, except for standard units of measurement. If in doubt about the spelling of terms, the international Webster dictionary should be used (<http://www.merriam-webster.com/>). Teeth are described by full name or using a two-digit FDI notation system.

Scientific names. The names of the bacteria are written in the text without abbreviations, meaning, in two words in italics (e.g. *Streptococcus sanguis*). When these names are mentioned a second time, the species name may be indicated by one of the first capital letters (e.g. *S. sanguis*). If the species name may cause confusion, the full name shall be provided. If the species name of the bacterium is written in the native language, it begins with a lower case letter, in a simple font (e.g. streptococci). Medicines, equipment, devices are described using generic rather than trade patented names. If the trade name is mentioned for the first time in the text, the manufacturer, city, country must be indicated: Inagel F-13® (Ina FoodIndustry Co., Ltd., Nagano, Japan).

Text distribution. The text is divided into chapters. If necessary, it can be divided into sections and subsections. Parts of the text are numbered in Arabic numerals. The title of the chapter is written in the centre of the page, in capital letters, in bold size 14 font: TITLE OF CHAPTER. Sections are numbered only within a chapter, so the section sequence number consists of the chapter and section numbers, which are separated by full stops, for example: 2.1., 2.2. The title of the section is written in lower case, except for the first letter, on the left edge, in bold size 12 font. If the text is further subdivided into subsections, these are numbered according to the same principle: the first digit indicates the chapter number, the second the section number and the third the subsection number, for example: 2.1.1., 2.1.2. The introduction, conclusions, bibliography and appendices are presented as separate chapters. They do not need to be numbered. Each chapter should start on a new page and the sections and subsections on the same page. A single line of text separates section and subsection titles before and after it. If the

chapter title is followed by a section title, a single line space is left between them. You cannot write a title on one page and start text on another.

BIBLIOGRAPHY

This section lists the sources of the literature used. There should be about 20-40 of them. Bibliographic descriptions should follow the requirements of the journals "Medicina" or "Stomatologija". References should be numbered according to the order in which they are used in the text, in square brackets: [1]; [2,4,7] or [2–5]. This section should follow the conclusions. Unpublished data and summaries may not be used. The names of all authors must be indicated in the references. When citing an author who is the author of a book chapter, the title of the book chapter should also be indicated. Cited using the Vancouver system and "Uniform requirements for articles submitted to biomedical journals" (JAMA. 1997;277(11):927–934), http://www.nlm.nih.gov/bsd/uniform_requirements.html).

Examples:

1. Standard magazine article in English.
Juodzbaly G, Wang HL. Soft and hard tissue assessment of immediate implant placement: a case series. *Clin Oral Implants Res.* 2007 Apr;18(2):237-43. doi: 10.1111/j.1600-0501.2006.01312.x. PMID: 17348889.
2. Article not in English
Ellingsen AE, Wilhelmsen I. Sykdomsangst blant medisin- og jusstudenter. *Tidsskr Nor Laegeforen.* 2002;122(8):785-7.
3. Chapter of a book
Meltzer PS, Kallioniemi A, Trent JM. Chromosome alterations in humansolid tumors. In: Vogelstein B, Kinzler KW, editors. *The genetic basis of human cancer.* New York: McGraw-Hill; 2002. p. 93-113.
4. Dissertation.
Borkowski MM. *Infant sleep and feeding: a telephone survey of Hispanic Americans [dissertation].* Mount Pleasant (MI): Central Michigan University; 2002.
5. Online magazine article.

Juodzbaly G, Wang HL, Sabalys G. Injury of the Inferior Alveolar Nerve during Implant Placement: a Literature Review. J Oral Maxillofac Res 2011;2(1):e1. URL: <http://www.ejomr.org/JOMR/archives/2011/1/e1/v2n1e1ht.htm>

EXAMPLE OF THE FIRST TITLE PAGE



LITHUANIAN UNIVERSITY OF HEALTH SCIENCES (12 pt*)
MEDICAL ACADEMY
FACULTY OF ODONTOLOGY
CLINIC OF MAXILLOFACIAL SURGERY

FULL NAME (14, bold)

year, group (12 pt)

**ORAL AND MAXILLOFACIAL SURGERY PATIENT'S ACADEMIC
MEDICAL HISTORY (16, bold)**

Supervisor (12 pt bold)

Scientific degree, full name, signature (12 pt)

Kaunas, year (12 pt)

**Note. The text printed in blue is indicative, explanatory by its nature.*

REPORT ASSESSMENT FORM

Assessment:

Lecturer:

(academic title, name and surname)

Date of assessment:

No	All parts	Criteria for assessing the structural and methodological requirements of the case history	Evaluation (1 - 10)
1	Complaints	Are the complaints marked correctly and do they correspond to the described pathology?	
2	Disease and life anamnesis	Is the anamnesis of the disease collected correctly and in sufficient detail? Is the life anamnesis collected correctly and in sufficient detail?	
3	Examination of the general condition	Is the examination of the general condition sufficient? Is it properly described?	
4	Examination of the condition of the face and jaws	Have all the organs of the face and jaws been examined? Is it properly researched and described?	
5	Preliminary diagnosis	Was a focused analysis properly performed and the right preliminary diagnosis selected? Is the preliminary diagnosis correctly recorded? Are additional data from the scientific literature provided?	
6	Clinical examination plan	Is the clinical examination plan properly justified and constructed? Have the research results been analysed and interpreted? Is additional scientific literature provided?	
7	Differential and clinical diagnosis	Is the differential diagnosis sufficiently extensive? Is the clinical diagnosis, including underlying disease, complications, and comorbidities, properly established and recorded? Is it based on	

		scientific literature sources?	
8	Treatment	Is the surgical and conservative treatment plan correctly drawn up? Is there evidence of the benefits of treatment selection? Are alternative treatments indicated using the scientific literature?	
9	Diary, epicrisis and prognosis	Is the diary detailed? Is the epicrisis adequately described, including a critical evaluation of all clinical and laboratory data and treatment and the onset, course, and outcome of the disease? Is the final diagnosis and prognosis of the disease outcome properly formulated?	
10	General requirements	Is the scope, structure, language, presentation, and text quality of the work appropriate?	
Final assessment*			
* Final assessment (1–10-point assessment average)			