

COMPREHENSIVE PATIENT GUIDE

JAW • TMJ • CHIN • AIRWAY • FACIAL ASYMMETRY • DIGITAL PLANNING

DOUBLE JAW SURGERY	TMJ SURGERY
GENIOPLASTY	SLEEP APNEA SURGERY
FACIAL ASYMMETRY	VIRTUAL SURGICAL PLANNING

Assoc. Prof. Dr. Emrah Dilaver
Oral and Maxillofacial Surgeon

WhatsApp: +90 539 838 64 76

About This Guide

This guide expands the patient-information framework used in the existing orthognathic surgery brochure into a more comprehensive resource. The original brochure's core pathway - understanding the jaw problem, participating in treatment, multidisciplinary care, diagnostic records, preparation, the surgical day, hospital recovery, swelling control, oral hygiene and nutrition - is retained and professionally reorganized. Additional sections on TMJ surgery, genioplasty, sleep apnea surgery, facial asymmetry and virtual surgical planning provide broader educational context for patients considering maxillofacial treatment.

Important

This material is educational. It does not replace an individual examination, diagnosis, treatment plan, anesthesia assessment or procedure-specific informed consent. The exact operation, timing, hospital stay, diet, medication, orthodontic sequence and follow-up protocol can differ between patients.

Contents

- 01 Understanding Orthognathic and Facial Skeletal Surgery
- 02 The Patient's Role in Treatment
- 03 Your Multidisciplinary Treatment Team
- 04 Common Jaw Problems and Their Effects
- 05 Examination, Records and Diagnostic Planning
- 06 Double Jaw Surgery
- 07 TMJ Surgery
- 08 Genioplasty
- 09 Sleep Apnea Surgery / Maxillomandibular Advancement
- 10 Facial Asymmetry
- 11 Virtual Surgical Planning
- 12 Preparing for Surgery
- 13 The Day of Surgery and Hospital Experience
- 14 Swelling, Pain and Early Recovery
- 15 Oral Hygiene After Surgery
- 16 Nutrition and Fluids
- 17 Recovery Timeline and Return to Daily Life
- 18 Potential Risks, Limitations and Expectations
- 19 Initial Online / International Patient Assessment
- 20 Frequently Asked Questions

01 UNDERSTANDING ORTHOGNATHIC SURGERY

Jaw deformities may be congenital, may become apparent during growth, or may follow trauma. Orthognathic surgery is performed to reposition the jaws and facial bones when skeletal alignment contributes to functional or facial problems. Surgery is only one part of treatment. Orthodontic treatment is often needed before and/or after surgery to coordinate the teeth with the corrected jaw position.

What orthognathic surgery aims to address

- Jaw-to-jaw and jaw-to-face imbalance.
- Difficulty achieving a functional bite because of skeletal position.
- Facial imbalance related to the maxilla, mandible or chin.
- Selected breathing or airway problems associated with skeletal anatomy.
- A combination of functional and facial concerns.

Why orthodontics may be necessary

Teeth often compensate for an abnormal skeletal relationship by tipping into positions that partially mask the jaw discrepancy. Presurgical orthodontics may intentionally move the teeth into a position that better reflects the true skeletal problem. After surgery, orthodontics may refine the bite and complete alignment.

Treatment is a process

Orthognathic treatment should be viewed as a sequence rather than a single operation: diagnosis, orthodontic preparation when required, surgical planning, surgery, early recovery, bite guidance, continued orthodontics and longer-term follow-up.

02 THE PATIENT'S ROLE IN TREATMENT

Preparation, surgery and postoperative recovery require time and active participation. Patients should understand the stages of treatment before beginning, including what is expected at each phase, the anticipated benefits, the limitations and the important risks.

Active participation

- Attend planned orthodontic and surgical appointments.
- Follow oral-hygiene, diet, elastic and medication instructions.
- Ask questions when any part of the plan is unclear.
- Inform the team about changes in health, medication or symptoms.
- Allow adequate time for swelling and soft-tissue adaptation before judging the final result.

Setting realistic expectations

A technically successful operation does not mean that every facial feature becomes perfectly symmetric or that every symptom is guaranteed to resolve. The aim is an anatomically appropriate, stable and patient-specific improvement.

03 YOUR TREATMENT TEAM

Complex jaw treatment is often multidisciplinary. The exact team depends on the diagnosis and may change from one patient to another.

Oral and Maxillofacial Surgeon

The surgeon evaluates the facial skeleton, jaws, bite, TMJs and surgical options, performs the operation and supervises surgical recovery.

Orthodontist

The orthodontist aligns and coordinates the teeth before and/or after surgery and works closely with the surgeon to establish the planned occlusion.

General Dentist and Dental Specialists

Dental health should be optimized before major jaw surgery. Periodontal, restorative, prosthodontic or endodontic care may be required when relevant.

Other Professionals

Depending on the problem, care may involve sleep medicine, ENT, anesthesiology, physiotherapy, speech therapy, pain medicine, neurology, rheumatology, nutrition or other specialties.

04 COMMON JAW PROBLEMS

More than one skeletal problem can exist at the same time. The visible facial appearance and the dental bite should therefore be evaluated together.

Class II / mandibular retrusion

The lower jaw is positioned relatively far back. The chin may appear retrusive and the dental relationship may make biting difficult.

Class III / mandibular prognathism or maxillary deficiency

The lower jaw may appear prominent, the upper jaw may be deficient, or both may contribute. Lower teeth may sit ahead of the upper teeth.

Open bite

The posterior teeth may contact while the anterior teeth remain apart. Skeletal vertical relationships, dental position, habits and other factors can contribute.

Facial asymmetry

The right and left sides of the maxilla and/or mandible may differ in height, length, position or rotation. The dental midlines and occlusal plane may also be affected.

Possible effects of jaw misalignment

Chewing difficulty, TMJ symptoms, speech difficulty, breathing or sleep-related problems, lip-closure difficulty and dissatisfaction with facial balance can occur, although symptoms vary between patients.

05 EXAMINATION, RECORDS & DIAGNOSTIC PLANNING

The surgeon and orthodontist may obtain records more than once because treatment changes the teeth and jaws over time. The purpose is to document the starting condition, plan treatment and compare progress.

Medical and dental history

- Previous operations and facial trauma.
- General health and relevant medical conditions.
- Medication, supplements, allergies and tobacco/nicotine use.
- Previous orthodontic, dental, TMJ or facial procedures.
- Planned future dental or facial procedures that may affect sequencing.

Physical examination

- How the upper and lower teeth meet.
- Dental and periodontal health.
- Jaw movements and mouth opening.
- Facial proportions, symmetry and profile.
- Smile, lip posture and tooth display.
- Tongue, oral cavity and airway-related anatomy when relevant.
- TMJ symptoms and joint examination when indicated.

Photographs and video

Standardized frontal, profile, three-quarter, smiling and intraoral photographs help document facial proportions and the bite. Video of smiling, speaking or mandibular movement may be useful in selected cases.

CBCT / CT imaging

Cone-beam CT can provide three-dimensional information about the jaws, facial skeleton, teeth, roots, impacted teeth, asymmetry and selected airway measurements. Imaging is chosen according to the clinical question; not every patient requires the same study.

Digital dental models

Intraoral scans or physical impressions can create dental models that show how the teeth fit together. Digital models can be integrated into 3D planning workflows.

Additional evaluations

- Sleep study when sleep-disordered breathing is being investigated.
- MRI when detailed TMJ disc and soft-tissue evaluation is required.
- ENT assessment for relevant nasal or upper-airway problems.
- Speech, physiotherapy, pain, neurological or other specialist assessment when indicated.

06 DOUBLE JAW SURGERY

Bimaxillary Orthognathic Surgery

Double jaw surgery repositions both the maxilla and mandible. It is considered when correction of one jaw alone would not adequately address the skeletal discrepancy, bite, facial proportions or selected airway objectives.

Typical indications

- Skeletal Class II or Class III relationship.
- Open bite or significant vertical discrepancy.
- Maxillary deficiency or excess combined with mandibular discrepancy.
- Occlusal cant or complex facial asymmetry.
- Selected patients with obstructive sleep apnea requiring skeletal advancement.
- Combined bite and facial-proportion problems.

Le Fort I osteotomy

The maxilla is mobilized through an intraoral approach and repositioned according to the plan. It may be advanced, impacted, moved downward, rotated or corrected asymmetrically.

Bilateral sagittal split osteotomy (BSSO)

The mandible is divided in a controlled manner on both sides and repositioned. Depending on the diagnosis, it may be advanced, set back or rotated. The inferior alveolar nerve is anatomically close to this operation, which is why altered lower-lip and chin sensation is an important consideration.

Fixation

The repositioned bones are generally stabilized with titanium plates and screws. The exact fixation strategy is selected according to the movement, bone anatomy and surgical plan.

Occlusion and elastics

A surgical splint may be used during or after surgery. Guiding elastics can help the patient close into the planned bite during early healing. The exact protocol varies.

Facial change

Moving the facial skeleton changes the support of the lips, cheeks, chin and lower facial contour. The relationship is not one-to-one: soft tissues respond biologically and the final appearance cannot be predicted with absolute precision.

Recovery

- Swelling is expected and generally increases during the early postoperative period before gradually decreasing.
- Nasal congestion may occur after maxillary surgery.
- Temporary difficulty chewing and reduced mouth opening are common.
- A liquid or non-chew diet is usually required initially.
- Most visible recovery occurs over weeks, while subtle facial settling may continue for months.

Important risks

- Bleeding, infection or wound problems.
- Temporary or persistent sensory disturbance.
- Unfavorable bone split or adjacent-structure injury.

- Bite discrepancy or need for orthodontic refinement.
- Relapse or positional change during healing.
- TMJ symptoms that may improve, remain unchanged or worsen.
- Sinus or nasal symptoms.
- Hardware-related symptoms.
- Residual asymmetry or need for additional treatment.

Individual treatment planning

The exact indication, movement, operative sequence and expected recovery must be determined after individual clinical and radiological assessment.

07 TMJ SURGERY

Temporomandibular Joint Surgery

TMJ surgery is not a single procedure. Treatment ranges from minimally invasive interventions to open reconstruction. The most important step is determining whether the patient's symptoms arise from structural joint pathology, muscles, neuropathic pain, headache disorders, systemic disease or a combination.

Symptoms that may prompt evaluation

- Persistent preauricular or joint-region pain.
- Locking or catching.
- Marked limitation of mouth opening.
- Progressive change in bite.
- History of trauma.
- Known degenerative or inflammatory joint disease.
- Facial asymmetry associated with condylar abnormality.

Imaging

CBCT or CT is useful for bony anatomy. MRI can show the articular disc, joint effusion and other soft-tissue structures. Imaging findings must be interpreted together with symptoms and examination.

Arthrocentesis

A minimally invasive lavage of the joint space that may be used in selected painful or restricted joints.

Arthroscopy

A small camera and instruments are introduced into the joint to inspect and treat selected intra-articular pathology.

Open TMJ surgery

Open procedures may include disc repositioning, disc surgery, removal of pathological tissue, reshaping or reconstruction depending on the diagnosis.

Total joint replacement

In selected end-stage conditions, severe ankylosis, major deformity, destructive disease or failed reconstruction, prosthetic joint replacement may be considered.

Rehabilitation

Jaw exercises and physiotherapy can be critical after TMJ surgery, especially when limitation of opening is part of the problem.

Limitations and risks

- Persistent pain despite technically appropriate treatment.
- Bleeding, infection and scarring.
- Facial nerve weakness in open approaches.
- Change in bite or mandibular movement.
- Sensory disturbance.
- Recurrent restriction or ankylosis in selected conditions.
- Need for revision or additional rehabilitation.

Individual treatment planning

The exact indication, movement, operative sequence and expected recovery must be determined after individual clinical and radiological assessment.

08 GENIOPLASTY

Bony Chin Repositioning

Genioplasty repositions the patient's own chin bone. It can change projection, vertical height and symmetry without moving the entire lower jaw.

What can be changed

- Horizontal advancement or setback.
- Vertical lengthening or shortening.
- Correction of chin deviation.
- Combined translation and rotation for three-dimensional asymmetry.

When isolated genioplasty may not be enough

If the main problem is mandibular retrusion, prognathism, malocclusion or a broader skeletal discrepancy, moving only the chin may camouflage the problem rather than correct it.

Procedure

A controlled osteotomy is generally made through an intraoral incision. The chin segment is mobilized, repositioned and stabilized with fixation hardware.

Planning

The chin is assessed relative to the lips, labiomental fold, mandibular border, lower facial height, facial midline, neck and the planned position of both jaws.

Recovery

- Swelling and tightness are expected.
- Temporary lower-lip/chin altered sensation can occur.
- The early postoperative contour is affected by edema.
- Soft-tissue adaptation continues after bony healing.

Risks

- Bleeding or infection.
- Sensory disturbance.
- Contour irregularity or residual asymmetry.
- Under- or over-correction.
- Hardware symptoms.
- Adjacent tooth-root injury.
- Need for revision in selected cases.

Individual treatment planning

The exact indication, movement, operative sequence and expected recovery must be determined after individual clinical and radiological assessment.

09 SLEEP APNEA SURGERY

Maxillomandibular Advancement (MMA)

Obstructive sleep apnea is characterized by repeated upper-airway narrowing or collapse during sleep. Treatment is multidisciplinary. In appropriately selected patients, maxillomandibular advancement enlarges the skeletal framework surrounding the upper airway by advancing the jaws.

Assessment

- Sleep history and symptoms.
- Formal sleep study when required.
- Sleep-medicine evaluation.
- Facial, dental and skeletal examination.
- CBCT/cephalometric assessment where appropriate.
- ENT assessment when nasal or pharyngeal pathology is relevant.

How MMA works

Advancement of the maxilla and mandible moves skeletal attachments and can increase the space available around the pharyngeal airway. The amount and direction of movement are individualized rather than determined by one universal number.

CBCT and airway volume

Three-dimensional imaging can help visualize airway anatomy and measure parameters such as volume or minimum cross-sectional area. An awake CBCT scan, however, does not replace a sleep study and does not by itself diagnose or grade OSA.

Facial planning

Airway objectives must be balanced with the bite, facial proportions, occlusal plane, lip support and chin position. This is one reason 3D planning is particularly useful in MMA.

After surgery

Postoperative sleep testing may be recommended to objectively assess response. Long-term outcome can also be influenced by weight, aging, nasal obstruction and other airway factors.

Risks and limitations

- General risks of double jaw surgery.
- Residual OSA despite improvement.
- Sensory changes.
- Bite or skeletal-stability issues.
- Need for continued sleep-medicine follow-up.

Individual treatment planning

The exact indication, movement, operative sequence and expected recovery must be determined after individual clinical and radiological assessment.

10 FACIAL ASYMMETRY

Diagnosis and Three-Dimensional Correction

Some facial asymmetry is normal. Treatment becomes relevant when asymmetry is clinically significant, progressive, functionally important, associated with an abnormal bite or important to the patient's treatment goals.

Possible skeletal sources

- Different mandibular lengths or ramus heights.
- Maxillary cant.
- Chin deviation.
- Asymmetric condylar growth or previous condylar trauma.
- TMJ degeneration or resorption.
- Developmental craniofacial differences.

Dental and soft-tissue components

Dental midlines and arch shape may be asymmetric. Soft tissues can also differ independently of the bone, including muscle bulk, fat distribution and skin thickness.

Assessment

Frontal facial analysis is essential, but the visible chin deviation alone does not identify the cause. 3D skeletal imaging, dental scans, occlusal-plane analysis and TMJ assessment may be required.

Treatment options

- Orthodontic correction.
- Isolated genioplasty.
- Single-jaw or double-jaw surgery.
- Asymmetric mandibular movements.
- Maxillary cant correction.
- TMJ treatment when joint pathology contributes.
- Selected secondary soft-tissue procedures.

Residual asymmetry

Surgery aims for meaningful improvement rather than mathematical perfection. Bone can be repositioned precisely, but soft-tissue adaptation on the two sides may differ.

Progressive asymmetry

When asymmetry is worsening, the underlying cause should be investigated before definitive correction. Active joint or growth-related pathology may change the timing or sequence of treatment.

Individual treatment planning

The exact indication, movement, operative sequence and expected recovery must be determined after individual clinical and radiological assessment.

11 VIRTUAL SURGICAL PLANNING

3D Planning and Surgical Transfer

Virtual Surgical Planning (VSP) combines digital skeletal and dental information to simulate surgery before the operation. It is particularly useful in double jaw surgery, facial asymmetry, genioplasty, airway surgery and complex reconstruction.

Data acquisition

- CBCT or CT of the facial skeleton.
- Digital intraoral scans or dental models.
- Clinical facial analysis and photographs.
- Occlusal and orthodontic information.
- Additional imaging when a TMJ-specific question exists.

Registration

Dental scans are aligned with the skeletal imaging to create a composite digital model with detailed teeth and bone information.

Analysis

The surgeon can assess midlines, occlusal plane, facial asymmetry, jaw relationships, translations and rotations in three dimensions.

Simulation

Virtual osteotomies are created and the jaws or chin are moved to test alternative strategies before surgery.

Plan review

The plan is evaluated for occlusion, skeletal feasibility, facial balance, airway objectives, TMJ considerations and anticipated stability.

Surgical transfer

Occlusal splints, cutting or positioning guides, patient-specific components or other transfer methods may be used to reproduce the approved plan.

What VSP cannot guarantee

VSP does not guarantee the final facial appearance. Soft-tissue prediction remains an estimate, and healing, muscle forces, fixation, orthodontics and intraoperative anatomy can influence the result.

Individual treatment planning

The exact indication, movement, operative sequence and expected recovery must be determined after individual clinical and radiological assessment.

12 PREPARING FOR SURGERY

Before surgery, the surgical plan is reviewed and practical preparation is completed. Good preparation can reduce avoidable problems and make the early recovery period easier.

Tobacco and nicotine

Smoking and other tobacco/nicotine exposure can increase surgical complications and impair wound and bone healing. Patients who use these products should discuss cessation with the treating team before surgery.

Plan recovery time

Arrange time away from work or school in advance. The appropriate duration depends on the operation, the patient's occupation and the speed of recovery.

Prepare the home environment

- Arrange appropriate adult support for the early postoperative period.
- Prepare suitable liquid and soft/non-chew foods.
- Have a blender or equivalent food-preparation method available if advised.
- Prepare prescribed oral-hygiene products and medications.
- Plan transportation to and from the hospital.

Medication review

Inform the surgical and anesthesia teams about prescription medicines, over-the-counter drugs, supplements and herbal products. Do not stop or change medication unless instructed by the responsible clinician.

Fasting

Follow the fasting instructions provided by the anesthesia team. The exact fasting interval and instructions regarding regular medication should be confirmed for the individual patient rather than assumed.

13 THE DAY OF SURGERY

Hospital staff may confirm your identity and planned procedure several times as part of routine surgical safety checks. An intravenous line is usually placed for fluids and medication. Major orthognathic procedures are generally performed under general anesthesia.

During the operation

- The planned osteotomies and skeletal movements are performed.
- Fixation is applied according to the procedure.
- A surgical splint may be used to establish or guide the bite.
- Elastics may be applied; the exact method varies by case.

Immediate recovery

After surgery, patients are monitored in the recovery area before transfer to the ward when appropriate. Facial numbness, swelling, drowsiness, nausea and discomfort can occur. Pain and nausea medication are provided according to clinical need.

Hospital stay

The length of stay depends on the procedure, medical condition and recovery. The existing orthognathic brochure describes a typical stay of approximately one to two days for its patient pathway, but individual cases may require a shorter or longer stay.

14 SWELLING, PAIN & EARLY RECOVERY

Facial swelling usually increases during the first postoperative days and then gradually decreases. Bruising or skin discoloration can occur. The amount of swelling varies considerably between patients and procedures.

Positioning

Keeping the head and shoulders elevated while resting can help during the early swelling phase when advised by the treating team.

Cold application

Cold packs may be used during the early period according to the surgeon's instructions. They should not be applied directly to the skin for prolonged periods.

Pain medication

Take prescribed medication according to the provided schedule. Contact the treating team if pain is unexpectedly severe, rapidly worsening or associated with other concerning symptoms.

Early mobilization

Patients are generally encouraged to begin safe mobilization after surgery when medically appropriate. Hydration is introduced early, and nausea is treated if necessary.

At home

- Prioritize hydration and adequate calorie/protein intake.
- Maintain oral cleanliness as instructed.
- Take medication correctly.
- Follow diet and activity restrictions.
- Attend scheduled controls.
- Do not judge the final facial result during the early swelling phase.

15 ORAL HYGIENE

Keeping the mouth and teeth clean is important for incision healing and comfort. The exact method depends on mouth opening, orthodontic appliances and the location of surgical wounds.

- Use a small or baby toothbrush if mouth opening is limited.
- Brush accessible tooth surfaces gently and regularly.
- Use prescribed toothpaste or mouth rinse according to instructions.
- An oral irrigator may be introduced later only if recommended and at an appropriate setting.
- Return gradually to normal brushing and flossing as access and healing permit.

Why hygiene matters

Food debris and plaque can accumulate around orthodontic appliances, elastics and intraoral incisions. A practical hygiene routine should therefore be discussed before discharge.

16 NUTRITION & FLUIDS

Swelling and reduced jaw function can make solid food difficult immediately after surgery. During the initial period, adequate hydration and calorie/protein intake are important for recovery.

Early liquid phase

The original patient brochure emphasizes fluids as a priority and describes approximately 6-8 glasses per day as a practical target. Individual fluid needs vary, particularly with body size, medical conditions, climate and postoperative status, so the treating team should provide individualized advice.

Meeting calorie and protein needs

- Use nutritionally dense liquids when normal intake is difficult.
- Commercial nutritional drinks can be useful when appropriate.
- Smoothies or blended foods can increase calorie and protein intake.
- A simple diet diary can help track fluids and food intake during the early phase.

Transition to non-chew foods

After the initial liquid period, many patients transition to soft or semi-solid foods that can be swallowed without significant biting or chewing. Examples may include soft eggs, well-cooked pasta, soft fish and similar foods, depending on the surgeon's instructions.

Protect healing bone

The key principle is to avoid loading or straining healing surgical sites before adequate bone healing has occurred. The timing of return to chewing is procedure-specific.

17 RECOVERY TIMELINE

Recovery is gradual and does not occur at the same rate in every patient. The following is a conceptual timeline rather than a fixed promise.

First days

- Swelling, congestion, numbness, fatigue and diet limitations are usually most noticeable.
- Hydration, medication, oral hygiene and safe mobilization are priorities.

First weeks

- Visible swelling usually decreases substantially.
- Energy and social comfort gradually improve.
- The bite may be guided with elastics.
- Diet remains restricted according to bone healing.

Following months

- Bone healing and orthodontic refinement continue.
- Sensation may continue to change or improve.
- Residual edema and soft-tissue adaptation can continue.
- Facial proportions are assessed more reliably after the early postoperative period.

Longer-term

Final assessment considers skeletal stability, bite, function, TMJ status, airway goals when relevant, facial balance and the patient's original treatment objectives.

18 RISKS, LIMITATIONS & EXPECTATIONS

Every operation has risks. The relevant risk profile depends on the specific procedure, anatomy, medical history and treatment plan. Procedure-specific consent is required before surgery.

General surgical considerations

- Bleeding and hematoma.
- Infection.
- Wound-healing problems.
- Swelling and bruising.
- Pain and temporary functional limitation.
- Anesthesia-related risks.
- Need for unplanned additional treatment in uncommon situations.

Orthognathic-specific considerations

- Temporary or persistent sensory disturbance.
- Bite discrepancy or orthodontic refinement.
- Relapse or skeletal positional change.
- TMJ symptoms.
- Sinus/nasal symptoms after maxillary surgery.
- Hardware-related symptoms.
- Residual asymmetry.

Aesthetic prediction

The facial skeleton can be planned and positioned with high precision, but the soft-tissue envelope responds biologically. Digital soft-tissue simulation is therefore an estimate, not a guarantee of the exact postoperative face.

Revision

Additional treatment or revision is not routine, but may be considered when there is a significant functional problem, healing complication, skeletal instability, hardware problem or clinically meaningful residual deformity.

19 INITIAL ONLINE / INTERNATIONAL PATIENT ASSESSMENT

An online review can help determine whether further orthognathic, TMJ, chin or airway assessment is reasonable. It is preliminary and does not replace an in-person examination.

Please send

- Clear front-facing facial photograph in natural head position.
- Clear side-profile photograph.
- Smiling facial photograph.
- Photograph showing the teeth together in the normal bite.
- Additional intraoral photographs if available.
- Panoramic or cephalometric radiograph if available.
- CBCT/CT if already obtained.
- For TMJ problems: MRI/CBCT/CT and reports if available.
- For sleep apnea: previous sleep-study report if available.
- A short summary of your main concern and previous treatment.



WhatsApp Consultation

+90 539 838 64 76

Scan the QR code to open WhatsApp and send your photographs and available records.

For safety and privacy, send only records you are comfortable sharing through the chosen communication channel. A definitive surgical plan is established after the necessary clinical and radiological assessment.

20 FREQUENTLY ASKED QUESTIONS

Will I always need braces before double jaw surgery?

Not always, but many conventional orthognathic pathways require orthodontic preparation. The need and duration depend on the dental compensation and planned surgical movement.

Can the final face be predicted exactly?

No. Skeletal movements can be planned in detail, but soft-tissue response, swelling and healing introduce biological variability.

How long does swelling last?

Most visible swelling decreases progressively over the first weeks, but subtle edema and soft-tissue adaptation may continue for several months.

Will my jaw be wired shut?

Not necessarily. Modern protocols often use fixation and guiding elastics, but the exact approach depends on the operation and surgeon's plan.

Is numbness normal after lower-jaw surgery?

Altered sensation of the lower lip and chin is common after BSSO. Recovery varies, and persistent sensory change is a recognized risk.

Does TMJ pain always require surgery?

No. TMJ-region pain has multiple possible causes. Surgery is considered only when the diagnosis and clinical situation support it.

Can genioplasty be performed with double jaw surgery?

Yes, when independent correction of chin position is indicated. It can also be performed as an isolated procedure in selected patients.

Can jaw advancement treat sleep apnea?

Maxillomandibular advancement can be an effective skeletal treatment in appropriately selected OSA patients, but selection requires proper sleep and craniofacial assessment.

Does a larger airway on CBCT prove sleep apnea is cured?

No. CBCT describes anatomy in an awake state. Objective sleep testing may be needed to evaluate treatment response.

Can facial asymmetry be made perfectly symmetric?

The goal is meaningful correction and balance, not mathematical perfection. Residual skeletal or soft-tissue asymmetry can remain.

Why is virtual planning useful?

It allows three-dimensional analysis, simulation of alternative movements and digital production of transfer tools such as splints or guides.

When can I chew normally?

This depends on the operation and bone healing. The treating surgeon should specify the diet progression and timing of return to chewing.

When can I return to work?

It depends on the extent of surgery, occupation and recovery. Patients should plan recovery time in advance and obtain an individualized recommendation.

When should I seek urgent help?

Difficulty breathing, uncontrolled bleeding, rapidly increasing swelling with systemic illness, loss of consciousness, chest pain or other severe unexpected symptoms require urgent medical assessment.

Final Note

The purpose of this guide is to make the treatment journey easier to understand. The correct operation is determined by diagnosis, not by the name of a procedure or a single facial feature. A complete evaluation allows the surgical plan to be tailored to the patient's bite, skeletal anatomy, TMJs, airway, facial proportions and individual priorities.

Assoc. Prof. Dr. Emrah Dilaver

Oral and Maxillofacial Surgeon

WhatsApp: +90 539 838 64 76

Educational patient-information material. Not a substitute for individualized medical advice or informed consent.