RESULTS: A total of 46,617 patients with orofacial clefts were identified, 14.6% with isolated cleft lip (CL), 51.7% with cleft lip and palate (CLP), and 33.7% with isolated cleft palate (CP). The incidence of patients requiring EFA increased from 2000 (3.7%) to 2012 (5.8%) (p<0.001). After controlling for comorbidities, the incidence was again found to increase throughout the study period (3.3% to 5.0%, p<0.001). Patients with comorbidities were noted to have higher rates of EFA that increase significantly between 2000 and 2012 (12.8% to 18.6%, p=0.019). Treatment in an urban teaching hospital was an independent risk factor for EFA (OR 4.65). Race and income were not independent risk factors.

CONCLUSION: The rates of EFA in patients with orofacial clefts increased substantially between 2000 and 2012, even after controlling for comorbidities. Patients with CP comprised the majority, which is consistent with a higher incidence of comorbidities in this population. The use of EFA is associated with a multitude of complications. Unnecessary use should be minimized.

P11.

CRANIOSYNOSTOSIS SURGERY: A PAINLESS PROCEDURE? A SINGLE INSTITUTION’S EXPERIENCE IN POST-OPERATIVE PAIN MANAGEMENT

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PURPOSE: Craniosynostosis is an extremely complex, invasive procedure often assumed to be associated with minimal pain. The purpose of this study was to investigate pain management trends at a tertiary academic institution.

METHODS: Retrospective chart review was performed of all surgical repairs for primary craniosynostosis at The Johns Hopkins Hospital from January 2009 to May 2013. Demographic information, admission data, and post-operative pain management were recorded.

RESULTS: 57 patients were identified. Mean age was 12.6 months, mean length of stay was 3.2 days. 86% were admitted to ICU, the remainder admitted to an inpatient floor. 93% were prescribed IV parent/nurse controlled analgesia (PCA), with fentanyl (73.6%) being most utilized. 98.3% were prescribed acetaminophen. No patients received NSAIDs. 98.3% were prescribed enteral opioids and oxycodone was the only opioid utilized. Transition from IV to enteral opioids occurred on post-operative day (POD) 0–2 in 45.6%, day 2–3 in in 52.7%, and after day 4 in 1.8%. 89.3% were prescribed opioids for discharge, most commonly oxycodone.

CONCLUSION: Despite pain service consultation and immediate initiation of IV PCA use, over 40% of patients were transitioned to oral opioids by POD 1 and mean length of stay was 3 days. Our results indicate that utilization of opioids via PCA can provide effective pain control without delaying transition to oral analgesics or discharge to home.

P12.

LE FORT FRACTURES IN KIDS: DO THEY HAPPEN? THE 30-YEAR EXPERIENCE AT THE JOHNS HOPKINS HOSPITAL

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PURPOSE: Currently, it is unclear whether Le Fort fractures occur in the pediatric population. The purpose of this study was to examine the etiology, incidence, and patterns of management of children with severe facial trauma associated with pterygoid-plate fractures.

METHODS: We studied all pediatric patients with pterygoid-plate fractures that presented to our institute from 1990–2013. Patient charts and radiological imaging were reviewed and demographics, fracture characteristics and treatment outcomes recorded. Fractures were categorized into three groups: Group 1: Simple, lacking key features of Le Fort-type