

Correspondence

Certification of maxillofacial disability and impairment

Dental professionals are included in the medical board of health institutions in India to give expert opinion on evaluation and procedure for certification of maxillofacial disability and impairment. The Extraordinary Gazette of India had issued guidelines for the purpose of assessing the extent of specified disability in a person under the Rights of Persons with Disabilities Act, 2016 (49 of 2016) as annexure II on 5 January 2018, but had omitted maxillofacial disability and impairment in the reported guidelines.¹ We attempt to detail maxillofacial disability and impairment that should be added in the revised guidelines of Rights of Persons with Disabilities Act, 2016 (49 of 2016). The maxillofacial disability and impairment may be measured in terms of loss of motion, loss of muscle strength and loss of coordination.²

The McBride method introduced by the American orthopedic surgeon McBride in 1936 is still used for evaluation and certification of maxillofacial disability and impairment in India.³ Evaluation of facial impairment and tooth loss is graduated as per the McBride method (Table I).³ Tooth loss is graduated for natural as well as artificial teeth and the maximum percentage admissible under the McBride method is 15%.

Conflict of interest. None declared

REFERENCES

- 1 The Gazette of India Extraordinary Part II—Section 3—Sub-section (ii) Section 56 of the Rights of Persons with Disabilities Act, 2016 (49 of 2016). Available at

TABLE I. McBride method for certification of maxillofacial disability and impairment³

Maxillofacial disability and impairment	Impairment whole percentage
<i>Evaluation criteria for impairment of face</i>	
I. Fracture of the jaws including disfigurement	
A. Maxilla united with malocclusion	8
B. Mandibular: malocclusion	8
C. Condylod process: painful occlusion	8
II. Ankylosis temporomandibular joint (motion limited 1/4 to 1/2 inch)	10
III. Loss of all teeth replaceable with prosthesis	15
IV. Loss of tongue: one-third	5
V. Loss of ear auricle	5
VI. Nose injury interfering with breathing	7
<i>Evaluation criteria of tooth loss</i>	
I. Tooth loss	
A. Anterior teeth (incisor)	0.3
B. Canine	0.45
C. Premolar	0.45
D. Molar	0.9
II. Implant crown	
A. Anterior teeth (incisor)	0.06
B. Canine	0.09
C. Premolar	0.09
D. Molar	0.18
III. Denture	
A. Pontic site	0.06–0.18
B. Removable denture site	0.09–0.27
C. Full denture	0.15–0.45
IV. Complete tooth loss	
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www.swavlambancard.gov.in/public/files/ProceduresGuidelines.pdf (accessed on 8 Jul 2022).

- 2 Shah N, Palan S, Mahajan A, Shah P, Shah R, Kumar P. Why and how maxillofacial disability and impairment due to trauma should be quantified for compensation: A need for nationwide guidelines. *J Maxillofac Oral Surg* 2014;**13**:425–30.
- 3 Ahn YW, Jang SM, Jeong SH, Jeon HM, Kim KH, Ok SM. A study on disability and impairment of dental disorders in Korea. *J Oral Med Pain* 2018;**43**:70–6.

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Narrative approaches to reviews

Garg *et al.* have used a narrative review to summarize the effect of non-operative therapies in the management of low back pain.¹ The results of the review have to be approached with caution for the following reasons. Narrative reviews or literature reviews are criticized for being neither systematic nor transparent in their approach to the synthesis of the literature.² Although the authors claim to have conducted a literature review, the search terms, databases and duration of the literature research have not been reported. The review must make sure that all or the majority of the pertinent research on the subject has been identified and included after clearly outlining its objectives. Along with parameters linked to variability, such as critical analysis of the articles included in the initial reviews, the quality and consistency of the evidence must be addressed.³

The next major drawback is that the authors have not defined the clinical question for which the review was done, which is a prerequisite for Grading of Recommendations Assessment, Development, and Evaluation (GRADE).⁴ The outcomes and comparator agents have not been specifically reported for many of the reviewed interventions. It is also not clear how the authors graded the quality of evidence using GRADE as the effect size for each outcome in absolute terms was not provided.⁵ Though this may be partially explained in terms of diverse characteristics of the studies considered, the authors could have considered alternative synthesis of results such as summary statistics of intervention effect estimates, vote counting based on direction of effect, and combining p values, and could have presented the results as a synthesis without meta-analysis.⁶

The results of some of the studied interventions have not been stated clearly. For example, the section on education does not specifically mention the outcomes and the comparator agent that were considered to determine if patient education was successful. Further, certain recommendations are based on old references (e.g. section on exercises). A recent meta-analysis has concluded that pilates, McKenzie therapy and functional restoration were more effective than other types of exercise treatment for reducing pain intensity and functional limitations.⁷ The results of a network meta-analysis had concluded that the pilates, resistance and stabilization/motor control, and resistance