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Knowledge, Attitudes and Practices of Selected Filipino Surgeons Regarding the Clinical Practice Guidelines on the Management of Isolated Mandibular Body Fractures in Adults

ABSTRACT

Objectives: To initially assess the knowledge, attitudes and practices of selected target users of the Clinical Practice Guidelines on the Management of Isolated Mandibular Body Fractures in Adults nationwide. Specifically, to assess the level of awareness of selected Filipino surgeons who are expected to use this clinical practice guideline and to identify gaps in knowledge and practices among these surgeons using the key action statements in the clinical practice guideline.

Methods:

Design: Cross-Sectional Study

Setting: Platform-Based Online Survey

Participants: 295 Otorhinolaryngologists – Head and Neck surgeons (ORL-HNS)/ Craniomaxillofacial surgeons (CMFS) and General surgeons (GS) / Plastic and Reconstructive surgeons (PRS) consultants and residents/fellows-in-training

Results: Among 295 surgeon respondents (47.46% ORL-HNS consultants), 75.25% were aware of PACMFS guidelines. In general, knowledge scores were high [median (IQR): 12 (11–13) vs 11 (IQR 9–13), $U = 11726$, $n_1 = 204$, $n_2 = 91$, $p < .001$; Mann-Whitney], with >90% accuracy for the tongue blade test (93.22%), non-contrast CT for fracture assessment (95.93%), closed reduction with maxillomandibular fixation for favorable fractures (98.31%), and ORIF with plates and screws for unstable fractures (98.64%); lower accuracy was observed for imaging modality sequencing (50.85%) and antibiotic selection (penicillin - 70.41%). Consultants and ORL-HNS/CMFS specialists demonstrated significantly higher knowledge and were guideline-concordant than trainees and other specialties. Attitudes toward multidisciplinary collaboration, evidence-based practice updates, and cost-effectiveness were nearly universal (over 99%). Most self-reported practices—such as requesting a panoramic radiograph (68.14%), obtaining plain mandibular radiographs when panoramic imaging was unavailable (91.53%), using Barton's bandage for temporary immobilization (89.83%), administering prophylactic antibiotics for mucosal/ skin breach (98.31%), and initiating analgesia at 4/10 pain score (85.71%)—were also guideline-consistent.

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Conclusion: Filipino surgeons in this survey demonstrated generally strong alignment with the published Philippine Academy of Craniomaxillofacial Surgery (PACMFS) Clinical Practice Guidelines for the management of isolated mandibular body fractures in adults, showing high knowledge and consistent self-reported adherence for key diagnostic steps, imaging selection when resources allow, temporary stabilization, and definitive operative decision-making.

Keywords: *mandibular fractures; maxillofacial injuries; practice guideline; self-administered questionnaire; otolaryngologists; general surgeons*

In 2021, the Philippine Academy of Craniomaxillofacial Surgery (PACMFS) published a clinical practice guideline (CPG) to aid in standardizing the management of isolated mandibular body fractures in adults.¹ This CPG is part of the Compendium of Department of Health (DOH)-approved clinical practice guidelines of the Republic of the Philippines (available from: <https://doh.gov.ph/dpcb/doh-approved-cpg/>). To the best of our knowledge, based on a search of HERDIN Plus, the Western Pacific Region Index Medicus and Global Index Medicus of WHO, the Directory of Open Access Journals, and MEDLINE (PubMed and PubMed Central), it is the only clinical practice guideline available both locally and internationally that specifically focuses on mandibular body fractures. Awareness and knowledge of this CPG is crucial in providing appropriate care to adult patients with mandibular body fractures.

The PACMFS CPG on isolated mandibular body fractures was created for all health care providers in any setting who encounter adults diagnosed with isolated mandibular body fracture. Since the fifth step of the Evidence-Based Medicine cycle involves evaluation of performance, the use and applicability of any CPG must be assessed after its dissemination.² This initial assessment of the knowledge, attitude, and practice of selected Filipino surgeons will aid in further health promotion and appropriate management of patients with isolated mandibular body fractures.

This study aimed to initially assess the knowledge, attitudes, and practices of selected target users of the Clinical Practice Guidelines on Management of Isolated Mandibular Body Fractures in Adults nationwide. Specifically, it aimed to assess the level of awareness of selected Filipino surgeons who are expected to use this clinical practice guideline and to identify gaps in knowledge and practices among these surgeons using the key action statements in the clinical practice guideline.

METHODS

With exemption from full ethics review granted by the Single Joint Research Ethics Board of the Department of Health, Republic of the Philippines (SJREB Protocol Code: SJREB-2025-65), this cross-sectional study invited Otorhinolaryngology – Head and Neck (ORL-HNS) surgeons/Craniomaxillofacial (CMF) surgeons and General surgeons (GS)/Plastic and Reconstructive surgeons (PRS) consultants and residents/fellows-in-training to participate in a platform-based online survey. Considered for inclusion were ORL-HNS, CMFS, GS, and PRS consultants, fellows-in-training, and residents who manage mandibular fractures. Participants were excluded from the study if they submitted more than 25% unanswered questions.

A self-administered 35-item multiple-choice survey questionnaire was constructed by the authors based on the published CPG. There were 35 questions with four multiple choice answers (A-D) each, distributed among three main sections: Knowledge (15 questions), Attitudes (10 questions), and Practices (10 questions). A statistician and clinimetrics specialist determined the internal consistency of the questionnaire through item-total and item-rest correlations. Reliability was measured using Cronbach's alpha (or the Kuder-Richardson Formula 20 for dichotomous items). The questionnaire was pre-tested among 10 expert respondents, and their feedback was considered in revising the questions/items in the questionnaire. These expert respondents were consultant members of the Philippine Academy of Craniomaxillofacial Surgery (PACMFS) and Philippine College of Surgeons (PCS) who actively manage mandibular fractures; these respondents were excluded from participation in the actual survey.

Prospective participants were recruited using convenience sampling through professional social media groups and email distribution lists. Invitations to participate were through the following platforms: Philippine Society of Otolaryngology Head and Neck Surgery (PSOHS) Viber channel and mailing list, Philippine College of Surgeons (PCS) Fellows Community Viber group and mailing list, Philippine Academy of Craniomaxillofacial Surgery (PACMFS) Viber group, Philippine Association of Plastic Reconstructive and Aesthetic Surgeons (PAPRAS) Viber group, Philippine Academy of Facial Plastic and Reconstructive Surgery (PAFPRS) Viber group, Philippine Residents of Otolaryngology Head and Neck Surgery (PROHNS) Viber group, University of the Philippines – Philippine General Hospital (UP-PGH) ORL-HNS Alumni Viber group and Faculty, East Avenue Medical Center (EAMC) Consultants and Staff Viber group, Jose R. Reyes Memorial Medical Center (JRRMMC) Viber group, and Southern Tagalog ENT Surgeons (STENTS) Viber channel. The questionnaire was available



in both Google Forms and Microsoft Forms format. Participants anonymously answered either of the available forms after providing their informed consent to participate.

Tabulation and analysis of data was performed using Microsoft Excel® for Mac V16.82 (Microsoft Corp., Redmond, WA, USA). Ordinal data was converted to numerical equivalents. The responses were summarized according to the following groups: ORL-HNS and CMFS consultants, ORL-HNS and CMFS residents/fellows-in-training, GS and PRS consultants, and GS and PRS residents/fellows-in-training. The subgroup analysis was performed per specialty (ORL-HNS vs. GS), subspecialty (CMFS vs. PRS), and level of expertise (consultants vs residents/fellows-in-training).

Descriptive statistics were used to summarize the general and clinical characteristics of the participants. Frequencies and proportions were used for categorical variables (nominal/ordinal). Continuous variables were assessed for normality using the Shapiro-Wilk test and, as all were non-normally distributed, were summarized using medians and interquartile ranges. Between-group comparisons by level of expertise, specialty, and subspecialty were performed for knowledge, attitude, and practice outcomes. Knowledge item-level proportions and attitude and practice item-level responses were compared using Chi square or Fisher’s exact tests, as appropriate. Total knowledge scores were compared using the Mann-Whitney U test. All complete responses per item that met the expected format were included in the analysis. Missing variables were neither replaced nor estimated. We used R version 3.2.1, 2015 (R Foundation for Statistical Computing, Vienna, Austria) and Python version 3.12.13 (Python Software Foundation, Beaverton, OR, USA) for primary data processing and analysis. A *p*-value of <.05 was considered statistically significant. Statistical analysis parameters such as median and IQR for the “Knowledge” data and Chi square and Fisher’s exact test for the “Attitude” and “Practice” data were based on a similar KAP study by Tabangay-Lim et al. regarding Clinical Practice Guidelines on thyroid nodules and malignancy.³

RESULTS

A total of 301 individuals responded to our invitation to participate in this survey. Since the survey was disseminated across multiple platforms with potentially overlapping memberships, the total number of unique individuals who received the invitation could not be determined. Consequently, a response rate cannot be calculated. Of these 301 participants, six were excluded (two did not accomplish the consent forms and four had more than 25% unanswered items) leaving 295 completed surveys for analysis.

Among 295 surgeon respondents, overall knowledge, attitudes, and practices regarding the management of isolated mandibular

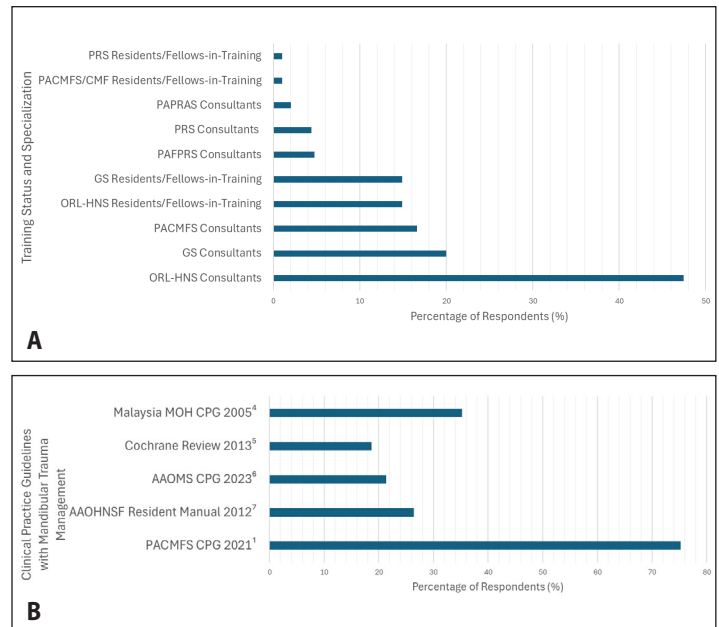


Figure 1. Respondent Profile and Awareness of Clinical Practice Guidelines on Mandibular Trauma Management. **A:** Distribution of respondents based on their training status and specialization. **B:** Distribution of respondents based on their awareness of the available clinical practice guidelines on mandibular trauma management

Table 1. Awareness of Mandibular Trauma Guidelines by Level of Expertise

	Consultant (n = 204)	Resident/ Fellow-in- Training (n = 91)	<i>p</i> -value
	Frequency (%)		
PACMFS 2021 Clinical Practice Guideline on Isolated Mandibular Body Fractures in Adults ¹	175 (85.78)	47 (51.65)	<.001
2012 American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAOHNHF) Resident Manual of the Trauma to the Face, Head, and Neck chapter on Mandibular Trauma ⁷	50 (24.51)	28 (30.77)	.326
2023 American Association of Oral and Maxillofacial Surgeons (AAOMS) Clinical Practice Guidelines for Oral and Maxillofacial Surgery section on Trauma Surgery ⁶	45 (22.06)	18 (19.78)	.774
2013 Cochrane Systematic Review on interventions for the management of mandibular fractures ⁵	47 (23.04)	8 (8.79)	.006
Clinical Practice Guideline on the Management of Unilateral Condylar Fracture of the Mandible by Ministry of Health Malaysia, 2005 ⁴	60 (29.41)	44 (48.35)	.003

Statistical test: Chi-square test

body fractures were largely aligned with the PACMFS clinical practice guideline,¹ with systematic variation by level of expertise and specialty. As shown on *Figure 1*, majority of the respondents were ORL-HNS consultants (47.46%) and 75.25% of the respondents showed awareness of the PACMFS CPG.¹ *Table 1* shows that consultants demonstrated significantly higher recognition of the 2021 PACMFS Clinical Practice Guideline on Isolated Mandibular Body Fractures in Adults¹ compared with trainees (85.78% vs 51.65%; $\chi^2(1, N = 295) = 37.57, p < .001$; Chi square). Specialty differences were also evident with ORL-HNS respondents reporting substantially higher awareness of the 2021 PACMFS guideline¹ (95.11% vs 41.67%; $\chi^2(1, N = 292) = 101.77, p < .001$; Chi square) and the 2012 AAO-HNSF resident manual⁷ (36.41% vs 9.26%; $\chi^2(1, N = 292) = 24.46, p < .001$; Chi square) reflecting strong alignment with specialty specific references. Conversely, general surgeons reported greater awareness of the 2023 AAOMS guideline⁶ (31.48% vs 11.41%; $\chi^2(1, N = 292) = 10.64, p = .001$; Chi square) and the 2005 Malaysian guideline on unilateral condylar fractures⁴ (71.30% vs 14.67%; $\chi^2(1, N = 292) = 92.70, p < .001$; Chi square).

Knowledge scores were high [median (IQR): 12 (11–13) vs 11 (IQR 9–13), $U = 11726, n_1 = 204, n_2 = 91, p < .001$; Mann-Whitney], with correct responses exceeding 90% for key items such as the tongue blade test (93.22%), non-contrast CT for fracture assessment (95.93%), closed reduction with maxillomandibular fixation for favorable fractures (98.31%), and ORIF with plates and screws for unstable fractures (98.64%); lower accuracy was observed for imaging modality sequencing (50.85%) and antibiotic selection (penicillin 70.41%). Consultants and ORL-HNS/CMFS specialists demonstrated higher knowledge scores and greater guideline-concordant responses than trainees and other specialties for tongue blade test for presumptive diagnosis [95.59% vs 87.91%, $\chi^2(1, N = 295) = 4.72, p = .030$; Chi square], selecting orthopantomography as the initial imaging modality [81.37% vs 59.34%, $\chi^2(1, N = 295) = 14.97, p < .001$; Chi square], correctly ordering imaging modalities by diagnostic accuracy, [58.82% vs 32.97%, $\chi^2(1, N = 295) = 15.81, p < .001$; Chi square], and requesting non-contrast computed tomography when available (98.53% vs 90.11%, $N = 295, p = .002$; Fisher's). Self-reported knowledge differed significantly between ORL-HNS and GS respondents. ORL-HNS respondents more frequently selected orthopantomography as the initial imaging modality for presumptive mandibular fractures [87.50% vs 52.78%, $\chi^2(1, N = 292) = 41.55, p < .001$; Chi square] and identified non-contrast computed tomography as the preferred imaging modality when available (98.91% vs 91.67%, $N = 292, p = .003$; Fisher's). The median total knowledge score was higher among ORL-HNS respondents than GS respondents [12.5 (IQR 11–13) vs 11.5 (IQR 10–13), $p < .001$; Mann-Whitney U test].

Attitudes showed near-universal agreement on cost-effectiveness and resource availability in treatment planning (99.02% vs 100%, $N = 294, p > .999$; Fisher's), openness to modifying practice based on new evidence and updates to clinical practice guidelines (100% in both groups), valuing multidisciplinary collaboration (99.51% vs 100%, $N = 295, p > .999$; Fisher's), incorporating patient preferences and socioeconomic factors into decision-making (100% vs 98.90%, $N = 294, p = .310$; Fisher's), assessing risk-benefit prior to treatment selection (100% in both groups), and alternative treatment options based on financial constraints (93.60% vs 97.80%, $N = 294, p = .160$; Fisher's). Divergence was observed when trainees were more likely than consultants to agree that there are circumstances in which riding a motorcycle without a helmet may be acceptable [18.89% vs 8.81%, $\chi^2(1, N = 283) = 4.99, p = .026$; Chi square]. Conversely, consultants more frequently agreed with routinely administering prophylactic antibiotics based on the assumption of a mucosal break [40.89% vs 27.78%, $\chi^2(1, N = 293) = 4.06, p = .044$; Chi square].

In practice, most respondents reported guideline-consistent behaviors for requesting a panoramic radiograph as the initial imaging modality (68.14%), 91.53% obtained plain mandibular radiographs when panoramic imaging was unavailable, 89.83% reported temporary immobilization using a figure-of-eight (Barton's) bandage, 98.31% administered prophylactic antibiotics in cases with concomitant mucosal or skin breach, and 85.71% reported initiating analgesia with paracetamol combined with a mild opioid at a pain score of 4/10. Self-reported practice differed between consultants and trainees in terms of panoramic radiograph as the initial imaging modality [74.51% vs 55.06%, $\chi^2(1, N = 293) = 10.00, p = .002$; Chi square], obtaining plain mandibular radiographs when panoramic imaging was unavailable (95.10% vs 86.36%, $\chi^2(1, N = 292) = 5.54, p = .019$; Chi square), and administering prophylactic antibiotics in cases with mucosal or skin breach without bone exposure, (100% vs 94.51%, $N = 295, p = .003$; Fisher's). In contrast, trainees more often reported routinely applying a figure-of-eight (Barton's) bandage for temporary immobilization [98.88% vs 87.19%, $\chi^2(1, N = 292) = 8.72, p = .003$; Chi square]. ORL-HNS respondents more frequently reported requesting a panoramic radiograph as the initial imaging modality for presumptive mandibular fractures compared with GS respondents [73.91% vs 60.38%, $\chi^2(1, N = 290) = 5.14, p = .023$ using Chi square]. In contrast, GS respondents more often reported using a figure-of-eight (Barton's) bandage for temporary immobilization [99.06% vs 85.87%, $\chi^2(1, N = 290) = 12.33, p < .001$; Chi square] and initiating analgesia with paracetamol plus a mild opioid at a pain score of 4/10 [99.06% vs 79.78%, $\chi^2(1, N = 289) = 20.18, p < .001$; Chi square]. Administration of prophylactic antibiotics in cases with



mucosal or skin breach without bone exposure was reported almost universally in both groups (98.37% vs 98.15%, $N = 292$, $p > .999$; Fisher's).

Table 2 shows the concordance between knowledge and self-reported practice for selected clinical decisions in mandibular fracture management where equivalent items were available across domains. A trend toward higher agreement between knowledge and practice was observed for the use of orthopantomography (OPG) as the initial imaging modality, in the use of figure-of-eight or Barton's bandage for temporary immobilization, prophylactic antibiotic administration in the presence of mucosal or skin breach, and closed reduction with MMF for 4-6 weeks in minimally displaced, favorable mandibular body fractures. These findings suggest that for selected guideline-concordant clinical decisions, correct knowledge was generally associated with corresponding clinical practice. However, this analysis was limited to item pairs with direct conceptual equivalence and does not establish causality.

Table 2. Knowledge-Practice Concordance for Selected Clinical Decisions in Mandibular Fracture Management

	Correct Answer	Wrong Answer	p-value
	Frequency (%)		
Practice Item 1	<i>Knowledge Item 2</i>		.056†
Agree	158 (71.82)	43 (58.90)	
Disagree	62 (28.18)	30 (41.10)	
Practice Item 2	<i>Knowledge Item 5</i>		<.001†
Agree	237 (93.68)	28 (71.79)	
Disagree	16 (6.32)	11 (28.21)	
Practice Item 3	<i>Knowledge Item 7</i>		.002‡
Agree	207 (100)	82 (94.25%)	
Disagree	0	5 (5.75)	
Practice Item 8	<i>Knowledge Item 10</i>		.005‡
Agree	267 (99.26)	23 (88.46)	
Disagree	2 (0.74)	3 (11.54)	

Statistical tests: †-Chi-square test; ‡-Fisher's exact test.

Excluded "Undecided" answers for Practice items.

Practice item 1 ↔ Knowledge item 2 (Orthopantomography as initial imaging)

Practice item 2 ↔ Knowledge item 5 (Figure-of-eight / Barton's bandage for temporary immobilization)

Practice item 3 ↔ Knowledge item 7 (Prophylactic antibiotics with mucosal/skin breach)

Practice item 8 ↔ Knowledge item 10 (Closed reduction with MMF for 4-6 weeks)

DISCUSSION

Among 295 surgeon respondents, overall knowledge, attitudes, and practices regarding the management of isolated mandibular body fractures were largely aligned with clinical practice guidelines, with systematic variation by level of expertise and specialty. Knowledge scores were high (median 12, IQR 10-13), with correct responses

exceeding 90% for key items such as the tongue blade test (93.22%), non-contrast CT for fracture assessment (95.93%), closed reduction with maxillomandibular fixation for favorable fractures (98.31%), and ORIF with plates and screws for unstable fractures (98.64%); lower accuracy was observed for imaging modality sequencing (50.85%) and antibiotic selection (penicillin 70.41%). Consultants and ORL-HNS/CMFS specialists demonstrated higher knowledge scores and greater guideline-concordant responses than trainees and other specialties (all $p < .05$ for imaging, stabilization, and antibiotic items). Attitudes showed near-universal agreement (>99%) on patient-centered care, cost-effectiveness, multidisciplinary collaboration, and guideline updating, while divergence was observed for helmet use (agreement with permissibility ranging from 3.92% to 25.00%), routine prophylactic antibiotics (27.78%-62.75%), and reliance on experience over guidelines (31.11%-59.62%). In practice, most respondents reported guideline-consistent behaviors for imaging, stabilization, antibiotics, and operative management (>85% for most items), although substantial variation persisted in conservative management of displaced fractures (44.23%-76.85%) and thresholds for additional imaging (52.94%-100%), particularly among non-specialist and trainee groups. Concordance with knowledge and self-reported practice was also demonstrated in management decisions such as the use of panoramic x-ray as initial imaging modality, Barton's bandage for temporary immobilization, prophylactic antibiotics for those with mucosal/skin breach, and closed reduction with MMF for 4-6 weeks.

Our survey shows broad alignment of Filipino surgeons' knowledge, attitudes, and self-reported practices with the locally-published, DOH-acknowledged PACMFS Clinical Practice Guideline (CPG) on isolated mandibular body fractures in adults¹ across specialties. This matters in settings where mandibular body fractures in adults are often linked to road traffic accidents. Local retrospective series from tertiary hospitals have consistently reported high proportions of mandibular fractures and a predominance of traffic-related injuries.^{8,9} Similar trauma epidemiology, with road traffic accidents as a major driver of craniofacial injury, also appears in regional data outside the Philippines.^{10,11} Against this background, the strong performance of respondents on core diagnostic and operative decisions suggest that key guideline messages have reached a large proportion of clinicians who manage mandibular fractures.

Overall awareness of the 2021 PACMFS CPG was high (75.25%), but awareness differed by expertise and specialty, with consultants and ORL-HNS/CMFS respondents reporting substantially greater familiarity than trainees and several non-ORL-HNS groups. In a similar KAP study done by Tabangay-Lim, most of their respondents (general surgeons)

were aware of the local guidelines than the counterpart international guidelines.³ This pattern mirrors findings from other guideline-focused KAP studies where local or specialty-endorsed guidelines tend to circulate more effectively within societies that develop them.³ Internationally, large surveys of clinicians managing connective tissue diseases also report guideline awareness and adherence across regions and professional roles, often reflecting training pathways and local networks rather than mere availability of documents.¹²

Consultants and ORL-HNS/CMFS specialists demonstrated higher knowledge scores and greater guideline-concordant responses than trainees and other specialties (all $p < .05$ for imaging, stabilization, and antibiotic items). Respondents demonstrated very high correctness on the tongue blade test (93.22%) and near-universal endorsement of CT when available (95.93%), temporary immobilization (86.10%), and ORIF decisions for unstable fractures (98.64%). These elements align with both the locally-published PACMFS CPG and established rules in trauma management.^{1,13,14} The extremely high selection of nasotracheal intubation (98.31%) also fits standard operative considerations for mandibular fixation and establishment of pre-morbid occlusion, where airway planning must accommodate maxillomandibular fixation and intraoral access.¹³

The strong preference for treatment selection such as observation for favorable non-displaced injuries, MMF for minimally-displaced favorable fractures, and ORIF for unstable fractures converges with established mandibular trauma guidelines.^{1,10} In contrast, studies among dental students often show broader variability in perceptions of mandibular fracture management and recovery expectations.¹⁵ Our current results therefore suggest that among practicing surgeons—ORL-HNS and GS, basic mandibular trauma principles appear well internalized.

Two knowledge gaps stand out: only half correctly identified the imaging accuracy sequence (50.85%), and antibiotic drug of choice responses varied (Penicillin 70.41%; Cefuroxime 27.21%). While practical algorithms often default to “CT if available, panoramic radiography if not,” clinicians still make tradeoffs in real-world settings where there are concerns of CT scan access and financial constraints. When clinicians lack confidence in the diagnostic performance of modalities, they may risk missed injuries or increase cost and radiation exposure, both of which matter in resource-variable environments. Antibiotic selection patterns point to a related implementation challenge: translating a guideline statement into consistent antimicrobial stewardship. The PACMFS CPG recommends prophylaxis for mandibular fractures with mucosal break and identifies penicillin as first-line, with alternatives for allergy.¹ Yet attitudes and practices suggest a tendency toward “just-in-case” antibiotic behavior: almost all respondents reported

administering prophylactic antibiotics for mucosal/skin breach without bone visualization (98.31%), while a sizable minority endorsed the assumption that every mandibular body fracture has a mucosal break. Fractures in tooth-bearing areas are also considered as contaminated¹⁶ and in the setting of underdeveloped and developing countries where patients with mandibular fracture may have poor oral hygiene, prophylactic antibiotics are beneficial.¹ Such responses may reflect fear of infection and complications, but they can also promote unnecessary exposure to broad-spectrum antibiotics when clearer diagnostic criteria and documentation of mucosal integrity would suffice.

Attitudes were overwhelmingly favorable toward cost-conscious, patient-centered, multidisciplinary care and openness to guideline updates. This resembles modern KAP studies in other domains, where clinicians express strong readiness to act on evidence yet still show gaps in translation into routine practice.¹⁷ In our present study, the most striking inconsistency involves conservative management of displaced and mobile fractures: 59.66% reported recommending observation with soft diet, despite near-universal endorsement of ORIF for unstable fractures. It is possible that economic constraints and access barriers may shape real-world practice even when clinicians endorse the operative ideal. Local series have documented that financial limitations and system factors can prevent operative management even in tertiary centers.¹⁴ Patient compliance considerations may also push clinicians toward either ORIF (to avoid prolonged MMF in non-compliant patients) or conservative pathways (when surgery is not feasible), consistent with the practical “context-first” approach described in mandibular trauma teaching.¹⁰

Near-universal endorsement of road safety and violence prevention aligns well with the PACMFS CPG’s prevention stance and the epidemiology of mandibular trauma.^{1,8,9} These findings support targeted implementation strategies rather than broad “awareness campaigns.” Embedding guideline algorithms into residency case conferences and audit-and-feedback loops may help reduce practice variability and promote consistent guideline-adherence.¹²

Several limitations must be considered. Selection bias may have been present as the pool of surgeons who answered our questionnaire may have included surgeons who were previously part of the original CPG working group. Moreover, our study relied on self-reported practices which may overestimate true guideline adherence due to recall and social desirability bias. Unequal subgroup sizes, particularly among PRS respondents, limited statistical power for some comparisons. Finally, our study only covered a sample of Filipino surgeons from the fields of Otorhinolaryngology – Head and Neck Surgery and General Surgery, with focus on those subspecializing in Craniomaxillofacial Surgery or Plastic and Reconstructive Surgery and the data may not represent the greater population of Filipino surgeons expected to use this CPG.



Future studies may incorporate mixed methods designs, including chart audits and qualitative interviews, to validate self-reported practices and explore contextual drivers of decision-making. Longitudinal evaluations of educational or systems-based interventions could further clarify how guideline uptake evolves over time and across training levels. Clinically, institutions may consider developing shared, cross-specialty protocols for mandibular trauma management that integrate guideline recommendations with local resource realities.

In conclusion, Filipino surgeons responding to our survey demonstrated generally strong alignment with the PACMFS clinical practice guideline for the management of isolated mandibular body fractures in adults, with high knowledge and favorable attitudes translating into largely guideline-concordant, self-reported practices

for key diagnostic steps, imaging selection when resources allow, temporary stabilization, and definitive operative decision-making. Nonetheless, meaningful variability persisted in areas where real-world constraints, clinical interpretation, and risk perception play a larger role, particularly in diagnostic imaging preferences, antibiotic stewardship, thresholds for additional imaging in the absence of classic signs, and the conservative management of displaced or mobile fractures. The consistent differences by training level and specialty suggest that implementation depends not only on awareness, but also on how guidelines are taught, reinforced, and operationalized within specialty training programs and institutional systems, underscoring the need for targeted educational and systems-level strategies to support consistent, context-appropriate application in routine clinical practice.

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