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Introduction.Cranial deformities problem in children is common today and became particularly acute with the launch of the campaign "Back to Sleep" by USA pediatricians association. Cranial deformities have increased risk for development of pathological manifestations of neurological, ophthalmological, otolaryngological, dental-alveolar etc. systems. The main problem that remain unclear now days is the incidence of cranial deformities in school children and their impact over organ and system and special to the head and neck areas. Materials and methods. 3923 school children were examined in 2012-2015 years. In these study children from three types of schools were involved.421 children were examined from schools with severe neurological disorders; 2157 children were from schools with special educational needs; and 1345 children from pre-university schools. Results. From 3923 children 632 (16%) were found with cranial deformities.12.4% of these children were found with cranial deformities of plagiocephaly type, 1%-with craniostenoses and 2.7% with other deformities.We found statistically true that in schools for children with neurological disabilities 44.18% cases were found with cranial deformations, in schools for children with special educational needs 17.71%, while in pre-university schools 4% (X^2 377.784 P□0.001). Conclusion.As a result of this study, it was found that the rate of cranial deformities is directly proportional to the nature of the examined school. Cranial deformities persist during school period of child's development. Higher incidence of cranial deformities was found in school children with neurological disabilities (48.18%) and lowest incidence was found in pre-university schools.

PP.289. MEDICATION-RELATED OSTEONECROSIS OF THE JAWS - CAN WE ADD STAGE 4?

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Background. Medication-related osteonecrosis of the jaw changed the nomenclature bisphosphonate-related osteonecrosis of the jaw because of the growing number of osteonecrosis associated with other anti-resorptive and antiangiogenic therapies. Patients must be considered to have MRONJ if ALL the following characterisics are present: Current or previous treatment with antiresorptive or angiogenic agents Exposed bone or bone that can be probed through an intraoral or extraoral fistula in the maxillofacial region, persisting for longer than 8 weeks No history of radiation therapy to the jaws or obvious metastatic diseases of the jaws. MRONJ adversely affects quality of life, producing significant morbidity. AAOMS (2014) defines the staging and treatment strategies for MROJ. Currently there is no unified classification, established for use of all professionals. Methods and materials. From 2010 to 2016 60 patients with current or previous bisphosphonate therapy were diagnosed with MRONJ and staged following AAOMS classification. 16 initially presented with bone sequestrum, evaluated by CT scan, which indicated the volume of surgical procedure. Results. Number of patients with MROJ is growing consistently. In Bulgaria most of them have already mobile bone fragments when they seek help. This stage – with bone sequestrum with or without infection - is not included in current staging systems, but can guide the surgeon easy (together with CT findings) for the treatment procedures. Conclusion. AAOMS classification is useful from clinical and diagnostic perspective. Adding stage 4 – presence of mobile sequestrum, evaluated by CT, will offer the surgical orientation to the treating surgeon.