



Original Research Article

Perception of oral and maxillofacial surgeons toward perioperative nutritional care: A KAP study

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Abstract

Introduction: To date, no data exist on the KAP of OFMS surgeons regarding postoperative nutritional care. The current prospective study aimed to identify nutritional knowledge, attitudes and practices of surgeons that can further benefit patients combating malnutrition.

Aim and Objective: Nutrition is an important factor in deciding the time taken to heal perioperative wounds. OMFS combines medicine and dentistry, extending beyond oral surgery to craniomaxillofacial surgery. Patients undergoing surgery related to nasal, oral and mental regions have even less access or a lower chance of meeting their daily nutritional requirements because of difficulty in chewing, swallowing or gulping, making it difficult for patients to recover quickly. Therefore, it becomes important for surgeons to have some nutritional knowledge, or they should actively refer patients to clinical dietitians for rapid recovery.

Materials and Methods: Data were collected via a questionnaire with 10 questions on KAP that was circulated online.

Results: Under the knowledge section, for 7 questions, fewer than 50% of the participants provided correct answers. The average level of knowledge was 43.4%, and the average level of attitude was 69.7%.

Conclusion: In conclusion, this study suggests that OMFS surgeons (trainees and practitioners) should have some nutritional knowledge to treat perioperative patients in an enhanced manner.

Keywords: Nutritional care, OMFS, Malnutrition, Surgery, Postoperative patient

Received: 25-07-2025; **Accepted:** 22-12-2025; **Available Online:** 05-01-2026

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1. Introduction

The science of nutrition involves understanding how the body uses food to meet its needs for growth, development, repair, and maintenance.¹ When the body does not receive enough vitamins, minerals, and other nutrients necessary to maintain healthy tissues and organ functions, malnutrition results.² To sustain life, cells must receive enough vitamins, minerals, fibre, water, carbohydrates, proteins, lipids, and micronutrients.³ Certain dietary deficiencies can affect the wound healing time and perioperative course. For example, ascorbic acid is required to synthesize collagen; hence, vitamin C deficiency can cause new wounds to heal more slowly or heal scars to lose strength.⁴

OMFS combines medicine and dentistry, extending beyond oral surgery to craniomaxillofacial surgery. The care of severe facial trauma, craniofacial deformity, oral oncology, temporomandibular disorders, facial anaesthetics, and treatment of oral diseases are all included in the field of maxillofacial surgery in India.⁵ Because it incorporates both highly specialized surgical principles and the concepts of dental surgery, this branch of medicine has always been distinctly unique in its emergence.⁶ Most procedures involve the oral cavity and alter its harmony. This, in turn, largely affects the general intake of nutrition by patients. Two-thirds of patients lose weight while hospitalized, and up to 40% of patients are undernourished when they are admitted.⁷

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Before the operative procedure, a skilled oral surgeon should be able to evaluate the patient's nutritional state and requirements. They should also be aware of the many nutritional support modalities and be able to recommend them for the patient's best interests.⁸ However, there is a knowledge gap among the OMFS regarding the perioperative nutritional care of patients undergoing surgery. There are no studies in the literature that have evaluated the perception of the OMFS regarding preoperative nutritional care. Hence, the purpose of this study was to evaluate the perioperative nutritional knowledge, attitudes and practices of OMFS practitioners and trainees.

2. Materials and Methods

A prospective purposive study was conducted for a period of 1 year from Jan 2023 to Jan 2024 among OMFS practitioners and OMFS trainees from all over the country. A well-structured questionnaire was adopted from a previous study⁹ designed to assess the knowledge, attitudes, and practices of participants regarding nutritional care among perioperative patients. Before circulation, this questionnaire was evaluated by two experts each from the field of OMFS and nutrition and dietetics. The content validity ratio was calculated to assess the validity of the questionnaire, which was found to be 0.73.

The participants who took part in the study voluntarily completed a questionnaire containing 30 validated closed-ended questions. The questionnaires were circulated and administered through Google Forms. Assessment of the content was performed by recording the responses of all the participants. The questionnaire consisted of 4 sections. The first section included questions related to sociodemographic details, and the second, third and fourth sections included questions related to knowledge, attitudes and practices, respectively, of the OMFS for nutritional care in perioperative patients.

The collected data for KAP were computed, and the results were obtained via SPSS software version 25. For knowledge, each correct answer was marked as one, and each incorrect answer was marked as zero. The total knowledge score was calculated by adding marks for all correct answers, and the percentage was calculated out of 10. For attitudes, for negative sentences, strongly agree was given a score of 1, agree was given a score of 2, disagree was given a score of 3, and strongly disagree was given a score of 4. Reverse coding was used for positive sentences. The total attitude score was calculated by summing the scores obtained for each sentence, and the percentage was calculated out of 40. The data are presented as the means $\pm$ SDs or frequencies (percentages). Cross tabulations were computed and compared via Fisher's exact test or the chi-square test. The Mann-Whitney U test was used to calculate the difference in individual attitude sentences between trainees and practitioners. The independent sample test was used to calculate the difference in percentage knowledge and percentage attitudes between trainees and practitioners.

Clinical trial registry - NA

3. Results

3.1. Statistical methods

The mean age of the study participants was 28.7 ± 6.5 years. There was no major difference in the percentage of males and females enrolled in the study. The maximum number of participants were from southern India. Among the trainees, higher percentages were from the second year or third year than from the first year, and most practitioners had 1–5 years of experience. Table 1 shows that more than 50% of the participants reported that nutrition was not a part of their training.

Knowledge - Table 2 shows that for the 10 questions, for two questions, more than 75% of the participants gave the correct answer; for one question, approximately 52.4% gave the correct answer; and for the remaining seven questions, fewer than 50% gave correct answers. A significantly greater percentage of practitioners gave a correct answer for the enteral route, which is the safest route to feed postoperative patients who have prolonged intensive care unit (ICU) care. In the case of long-standing postoperative feed, PEG feeds are the most ideal form of feeding, with the central line being the most ideal route to administer parenteral nutrition and the Harris-Benedict equation being used to assess caloric requirements compared with those of trainees ($p < 0.05$). No other significant differences were observed.

Attitude - Table 3 shows that, from the five negative statements, the best attitude was for postoperative care of a patient, which can be managed without a dietician, with 74.7% of the participants reporting that they strongly disagreed. According to the positive statements, the best attitude was that nutrition plays an important role in the management of various diseases, with 99% of the participants reporting strongly disagree.

Table 4 shows that trainees had better attitudes for “you have enough knowledge regarding postoperative nutrition”, “the enteral route mimics normal physiologic function” and “the route of administration determines individual response to injury” than practitioners did, as they had higher average scores ($p < 0.05$). On the other hand, practitioners had a better attitude toward obtaining dietary counselling for patients undergoing surgery than trainees did ($p < 0.05$).

Marks obtained for knowledge and attitudes - The average level of knowledge was 43.4%, and the average level of attitudes was 69.7%. Compared with trainees, practitioners had significantly greater knowledge ($p < 0.05$). No significant differences were observed in the attitudes of the trainees and practitioners ($p > 0.05$) (**Figure 1**).

Table 5 shows that practices related to the nutrition care process were significantly different between trainees and practitioners in terms of the proportion of patients for whom

nutritional assessment was undertaken, the frequency of weighing patients on admission, the reason for weighing patients, the protocol followed when patients with prolonged ICU stays had abnormal routine values and the frequency of conducting a protein analysis test on postoperative patients ($p < 0.05$). Compared with practitioners, a greater percentage of trainees reported that they conducted nutritional assessments on all patients and weighed patients to calculate anaesthesia. On the other hand, a greater percentage of practitioners reported that they always weighed patients on admission, consulted a dietician if values were above routine values or conducted protein analysis on patients once a week than did trainees.

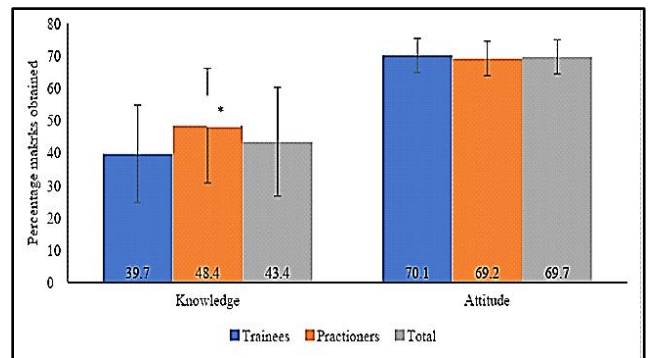


Figure 1: Total knowledge and attitudes percentage obtained

Table 1: Demographic data

	Frequency	Percentage
Gender		
Females	96	46.6
Males	110	53.4
Zone in India		
Eastern	12	5.8
Western	40	19.4
Northern	22	10.7
Southern	120	58.3
Central	12	5.8
Are you a		
Trainee	118	57.3
Practitioner	88	42.7
If Trainee, which year are you in?		
First year	24	
Second year	40	
Third year	54	
If practitioner, years of experience		
1 – 5 years	66	75
6 – 10 years	8	9.1
>10 years	14	15.9
Nutrition a part of training program		
Yes	68	33
No	116	56.3
Not sure	22	10.7

Table 2: Knowledge of nutrition care for postoperative patients

	Trainee s (n=118)		Practitioner rs (n=88)		Total (n=206)		P- value
	N	%	N	%	N	%	P-value
1g of protein + 1 g of carbohydrate + 1 g of fat provides 17 kcals	38	32.2	40	45.5	78	37.9	0.052
Immune nutrients in diet increase cellular defense, lower systemic inflammation and curb free radicals	98	83.1	70	79.5	168	81.6	0.587
Serum albumin is the most important biomarker to assess nutritional status	86	72.9	70	79.5	156	75.7	0.325
The normal range for serum albumin is 3.4 to 5.4 g/dl	52	44.1	48	54.5	100	48.5	0.159
Both standardized commercial sachets and blenderized home cooked meals are equally	42	35.6	38	43.2	80	38.8	0.312

helpful							
TLC and BMI can be used to assess immune competence	66	55.9	42	47.7	108	52.4	0262
The enteral route is the safest route to feed postoperative patients who have prolonged ICU care	6	5.1	14	15.9	20	9.7	0.016
In case of long standing post-Operative feed, Percutaneous Endoscopic Gastrostomy feeds are the most ideal form of feeding	20	16.9	26	29.5	46	22.3	0.042
Central line is the most ideal route for administering total parenteral nutrition	16	13.6	30	34.1	46	22.3	0.001
Harris Benedict equation is used to assess calorie requirement	44	37.3	48	54.5	92	44.7	0.016

Table 3: Attitudes towards the nutritional care process for postoperative patients

	N	%	N	%	N	%	N	%
Negative sentences								
	Strongly agree		Agree		Disagree		Strongly disagree	
Oral and Maxillofacial Surgeons are very knowledgeable in nutritional matter.	18	8.7	94	45.6	80	38.8	14	6.8
You have enough knowledge regarding Postoperative nutrition.	10	4.9	92	44.7	86	41.7	18	8.7
Postoperative care of a patient can be managed without a dietician.	14	6.8	38	18.4	136	66	18	8.7
It is doctor's responsibility to assess the nutritional status of the patient.	88	42.7	112	54.4	6	2.9	-	-
Appropriate and adequate nutritional support is normally provided in the surgical ward.	34	16.5	102	49.5	68	33	2	1.0
Positive sentences								
	Strongly disagree		Disagree		Agree		Strongly agree	
It is mandatory to get dietary counselling for patient undergoing surgery.	-	-	24	11.7	116	56.3	66	32
It is important to assess the nutritional status of every patient admitted to the ward.	-	-	14	6.8	100	48.5	92	44.7
Nutrition has an important role in management of various diseases.	-	-	2	1.0	82	39.8	122	59.2
Enteral route mimic normal physiologic function.	-	-	32	15.5	140	68	34	16.5
Route of administration determines individual response to injury.	2	1.0	18	8.7	126	61.2	60	29.1

Table 4: Attitudes towards the nutritional care process for postoperative patients compared between trainees and practitioners

Data are presented as the mean±SD.

	Trainees (n=118)	Practitioners (n=88)	P- value
Negative Sentences			
Oral and Maxillofacial Surgeons are very knowledgeable in nutritional matter.	2.4±0.7	2.6±0.8	0.153
You have enough knowledge regarding postoperative nutrition.	2.6±0.7	2.4±0.7	0.033
Postoperative care of a patient can be managed without a dietician.	2.7±0.7	2.9±0.7	0.105
It is doctor's responsibility to assess the nutritional status of the patient.	1.6±0.6	1.6±0.5	0.983
Appropriate and adequate nutritional support is normally provided in the surgical ward.	2.2±0.7	2.2±0.7	0.570
Positive sentences			
It is mandatory to get dietary counselling for patient undergoing surgery.	3.1±0.6	3.3±0.6	0.021
It is important to assess the nutritional status of every patient admitted to the ward.	3.4±0.6	3.3±0.7	0.349

Nutrition has an important role in management of various diseases.	3.6±0.5	3.6±0.5	0.947
Enteral route mimic normal physiologic function.	3.1±0.5	2.8±0.6	0.001
Route of administration determines individual response to injury.	3.4±0.5	3.0±0.6	0.001

Table 5: Practice of the nutritional care process for postoperative patients

	Trainee s (n=118)		Practitioners (n=88)		Total (n=206)		P-value
	N	%	N	%	N	%	P-value
Criteria used to assess nutritional status							
Height, weight and body mass index	64	57.1	52	59.1	11	58.0	0.161
Diet history	26	23.2	12	13.6	38	19	
Protein analysis	22	19.6	24	27.3	46	23	
Proportion of patients on which nutritional assessment is undertaken							
All	38	32.2	20	22.7	58	28.2	0.005
Some patients	24	20.3	36	40.9	60	29.1	
Critical care patients	52	44.1	32	36.4	84	40.8	
None	4	3.4	0	0	4	1.9	
Frequency of Weighting patients on admission							
Never	4	3.4	2	2.3	6	2.9	0.002
Rarely	22	18.6	2	2.3	24	11.7	
Occasionally	36	30.5	26	29.5	62	30.1	
Always	56	47.5	58	65.9	114	55.3	
Reason to weigh patient							
To calculate anaesthesia dose	84	71.2	44	50	128	62.1	0.001
For medical records	30	25.4	30	34.1	60	29.1	
For malnourished patients	4	3.4	14	15.9	18	8.7	
Frequency of discussing nutritional status and nutritional management of patients during ward rounds							
Pertaining to patients	18	15.3	12	13.6	30	14.6	0.886
Sometimes	60	50.8	48	54.5	108	52.4	
Always	40	33.9	28	31.8	68	33.0	
Protocol followed when patients in prolonged ICU stay having abnormal routine values							
Consult dietitian	18	15.3	20	22.7	38	18.4	0.043
Refer to a physician	22	18.6	6	6.8	28	13.6	
Discuss diet options	6	5.1	2	2.3	8	3.9	
All of the above	72	61.0	60	68.2	132	64.1	
Consider conducting a protein analysis test on postoperative patients							
Yes	52	44.1	32	36.4	84	40.8	0.370
No	16	13.6	10	11.4	26	12.6	
May be	50	42.4	46	52.3	96	46.6	
Frequency of conducting a protein analysis test on postoperative patients							
Once/week	44	37.3	44	50	88	42.7	0.003
Once/month	40	33.9	18	20.5	58	28.2	
Once/six months	18	15.3	4	4.5	22	10.7	
Never	16	13.6	22	25	38	18.4	
Method to assess the position of naso-gastric tube							
Clinically (epigastrium)	44	37.3	24	27.3	68	33	0.258
Radiological assessment	12	10.2	6	6.8	18	8.7	
Both	56	47.5	54	61.4	110	53.4	
None	6	5.1	4	4.5	10	4.9	
Frequently suggested nutritional supplement							
Multivitamin	60	50.8	36	40.6	96	46.6	0.333
Protein	52	44.1	46	52.3	98	47.6	
Omega-3	4	3.4	2	2.3	6	2.9	
None of the above	2	1.7	4	4.5	6	2.9	

4. Discussion

Nutritional status is recognized as an essential component of surgical recovery regimens. OMFS, while crucial for treating various conditions in the jaw, mouth, and neck regions, often necessitates limitations on postoperative food intake. This restricted diet can negatively impact patients' health by hindering their ability to absorb essential nutrients, potentially leading to malnutrition. To treat the postoperative stress response and minimize the loss of muscle mass, strength, and functionality, adequate nutritional intake is necessary.¹⁰ A nutritional deficiency should be treated with a balanced diet and dietary supplementation of the deficient nutrient before surgery.¹¹ Early dietary intake after surgery not only guarantees a shorter hospital stay but also helps patients maintain their body composition.¹² A study by Brown, T., Edwards, A., et al. concluded that early identification and management of malnutrition is necessary to minimize the risk of postoperative complications and reduce the length of stay and should be considered a key component of rehabilitation programs.¹³

The Likert scale was used to assess the attitudes of participants; although 74.7% of participants disagreed that dietitians are unnecessary for perioperative care, this study suggests a positive attitude toward the role of nutritional management in improving recovery and potentially reducing hospital stays.¹²

In the present study, 15.5% of practitioners correctly identified the enteral route as the safest feeding method for perioperative patients requiring extended intensive care unit (ICU) care. A study conducted by Seron-Arbeloa, C., Zamora-Elson, M., et al. reported that enteral nutrition is preferable to parenteral nutrition because it is less expensive and generally results in better patient outcomes—including fewer infections and shorter hospital stays.¹⁴ A total of 29.5% of surgeons identified PEG as the ideal feeding method for long-term postoperative needs, which aligns with the literature published by Rahnemai-Azar, A. A., Rahnemai-Azar, A. A, etc., suggesting that PEG is the preferred route because of its superior access to surgical methods.¹⁵

Moreover, 22.3% of surgeons (trainees and practitioners) believed the central line to be the most suitable route for PN administration; this approach may not be optimal. Research conducted by Berlana, D. (2022) emphasized the use of central lines due to the hypertonicity of PN solutions, but alternative routes can be explored to minimize catheter-related complications.¹⁶

The best attitude was that nutrition has an important role in the management of various diseases, with 99% of participants reporting strongly disagree, which was further supported by another study published by Gropper, S. S. (2023). Nutrition is often considered a lifestyle factor that

leads to the prevention of many chronic diseases, including obesity, cardiovascular disease, hypertension, stroke, type 2 diabetes, metabolic syndrome, some cancers, and, seldom, some neurological diseases.¹⁷

Our results revealed interesting differences in knowledge and attitudes between OMFS trainees and practitioners. The trainees had a more positive attitude toward their knowledge of perioperative nutrition ($p < 0.05$) and toward the enteral route, which mimics normal physiological function ($p < 0.05$). Furthermore, the trainees also believed that the route of administration influences individual responses to injury ($p < 0.05$). On the other hand, practitioners strongly believed in the necessity of dietary counselling for surgical patients ($p < 0.05$). Practitioners presented significantly higher knowledge scores than did trainees ($p < 0.05$). Interestingly, no significant differences in overall attitudes were detected between the two groups ($p > 0.05$).

Practices related to the nutritional care process were significantly different between trainees and practitioners for several patients for whom nutritional assessment was undertaken, for whom the weight of patients on admission was measured, for whom the patients were weighed, for whom the protocol followed when patients with prolonged ICU stays had abnormal routine values and for whom a protein analysis test was frequently conducted on perioperative patients ($p < 0.05$). A total of 32.2% of the trainees conducted nutritional assessments on all patients. On the other hand, 65.9% of practitioners reported that they always weighed patients on admission, and compared with trainees, 50% of practitioners conducted protein analysis on patients once a week.

This study has potential limitations, one of which is that it is an observational KAP study. Owing to resource constraints, the study was conducted with a limited number of participants. To our knowledge, this study is the first to investigate the importance of the KAP of the OMFS regarding perioperative nutrition, even though there are multiple studies on the use of the OMFS to evaluate the impact of nutrition on patients with oral injury and their quality of life, and there is no strong evidence suggesting that their KAP is related to perioperative care.

5. Conclusion

In conclusion, this study suggests that OMFS surgeons (trainees and practitioners) should have some nutritional knowledge to treat perioperative patients in an enhanced manner. Limited nutritional knowledge among OMFS may necessitate referrals to registered dietitians in the pre- and postoperative phases, potentially leading to shorter hospital stays and improved patient recovery. This approach could promote a more holistic model of patient care management.

6. List of Abbreviations

1. OMFS - Oral and maxillofacial surgery
2. PEG - Percutaneous endoscopic gastrostomy
3. PN - Parenteral Nutrition
4. KAP - Knowledge, attitudes and practices

7. Source of Funding

None.

8. Conflict of Interest

None.

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Cite this article: Somani B, Lakshmi Rathan AC, Sapna DP S, Somani C. Perception of oral and maxillofacial surgeons toward perioperative nutritional care: A KAP study. *J Advanc Oral Health.* 2025;2(2):55-61.