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Sunil Bennur · Ramen Sinha · Suresh Menon

Unusual maxillofacial injury

A 60-year-old female who resides at a remote village of Maharashtra, was referred to our department from nearby civil tertiary care hospital. History, as narrated by her relatives revealed that her husband in a drunken stupor had hacked at her face with an axe after a quarrel. Consequently, she bled profusely and received first aid care at a primary health centre nearby. She was immediately evacuated by road to the tertiary centre about 7 hours drive away.

On examination, the patient was an asthenic and poorly nourished elderly female. She was fully conscious with a Glasgow coma scale score being 15/15. Vital signs record revealed: BP: 90/60 mmhg, pulse: 99 bpm, respiration: 18/min. There was a 12cm long, laceration on the left side of the face extending from 2cm behind the auricle to 5 cm short of the left ala of nose (Fig. 1) transecting the pinna of the ear. Mouth opening was 15 mm between the edentulous alveolar ridge in the midline. Intra-oral examination did not reveal any significant abnormality. Considering a possibility of hypovolemic shock it was decided to infuse 2 units of Ringer's Lactate immediately. Treatment plan included surgical exploration and debridement under LA and subsequently a definitive management under GA after all the necessary investigations. Patient was scrubbed and draped on the gurney in which she was brought to the department. Nine 1.8 ml cartridges of Lignocaine 2% with 1:80000 adrenaline were infiltrated in and around the wound. Antibiotic prophylaxis consisted of Ampicillin 500mg, Gentamicin 40 mg, and Metronidazole 500mg, administered IV. Diclofenac sodium 75mg was given for pain relief. Exploration of the wound revealed transection through parotid gland and masseter, the mastoid process, styloid process and the mandibular ramus just missing the carotids. The comminuted mastoid, coronoid and styloid processes were extracted. Attempts at deep exploration under local anaesthesia met

Fig. 1 Deep laceration on the cheek preoperatively

Fig. 2 Rigid fixation using titanium plates and screws

Fig. 3 Panoramic radiograph showing satisfactory reduction with miniplates and screws

with no resistance as the patient tolerated the procedure. Her vital signs also remained stable. Consequently we decided to proceed further with definitive treatment. The lateral surface of ramus was exposed, reduced and fixed using titanium implants (Fig. 2). Hemostasis was achieved and closure was done in layers using 3-0 Vicryl® and the skin was sutured using 4-0 monofilament polypropylene. Postoperatively the patient recovered uneventfully except for left sided facial palsy secondary to severance of the main trunk of the facial nerve. Postoperative radiograph revealed satisfactory reduction of the fractured ramal segment (Fig. 3). The patient was discharged after 4 days.

We consider this to be an unusual case because of uncommon mechanism of injury

as well as her successful management under local anesthesia without sedation and undue discomfort to the patient.

References

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Sunil Bennur

E-mail: sunilbennur76@yahoo.co.in