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An unusual presentation of a missed oral foreign body: A case report

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Abstract: Penetrating injuries to face have variable presentations. Sometimes the clinical findings get missed in view of other systemic injuries. Accurate examination and timely intervention are important to prevent any devastating injury. Most of these injuries are only soft tissue without any major structure being involved.
Keywords: foreign bodies, accidental penetration, soft tissue.

INTRODUCTION

Penetrating foreign bodies to face are usually not missed. An exception to such case is our case where the foreign body was missed on first presentation. Accurate early diagnosis in such cases of accidental penetration of foreign bodies depends on patient's history, clinical examination, radiography and specialized investigations like computed tomography or endoscopy etc.

CASE REPORT

A 24 year old young man reported to the emergency department of our hospital with history of assault. According to him, some unknown object was hit on left cheek and left chest. On examination, he was found to have diaphragmatic hernia on left side. He was immediately taken for laparoscopic repair of hernia under general anesthesia. Later in the Post operative period, patient complained of restricted mouth opening. Plastic surgery consult was taken. There was sutured wound over left cheek. Nothing could be felt inside from it. Intraoral examination showed a small puncture wound in left buccal area (1 cm superior to opening of parotid duct) No abnormal mobility was found on facial bony examination. X ray paranasal sinus, (water's view) was not clear in showing any significant finding (figure 1). On getting CT with 3D reconstruction there was present a triangular linear hyper dense object piercing left masseter muscle anterior to the ramus of the mandible and seen piercing the pterygoid muscle with tip lying just lateral to the pharyngo mucosal space at approx. distance of 6mm (figure 2 and 3).

Patient was taken up for exploration and foreign body removal under GA with oral intubation. After initial failed attempt from cheek laceration, the foreign body was easily extracted from intraoral buccal laceration with slightest manipulation (picture1). The track was thoroughly irrigated with betadine and saline. The tract was far from tract of parotid duct. Cheek wound was also thoroughly irrigated. Its margins were freshened and sutured. Post operatively patient had adequate mouth opening. There were no signs of facial nerve injury or wound infection. Sutures were removed and patient was discharged on 5th post operative day with adequate mouth opening (picture 2).

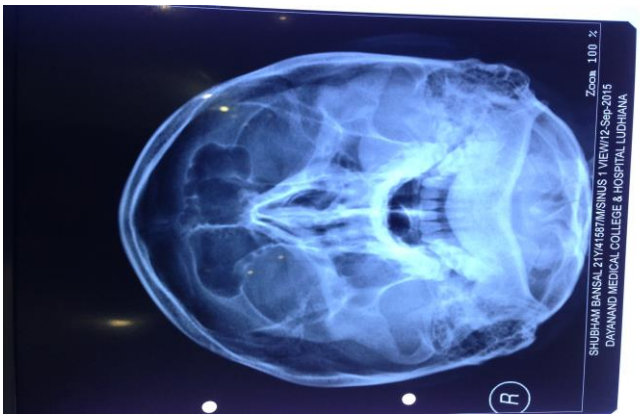


Fig 1: X ray PNS (waters view) not depicting foreign body clearly

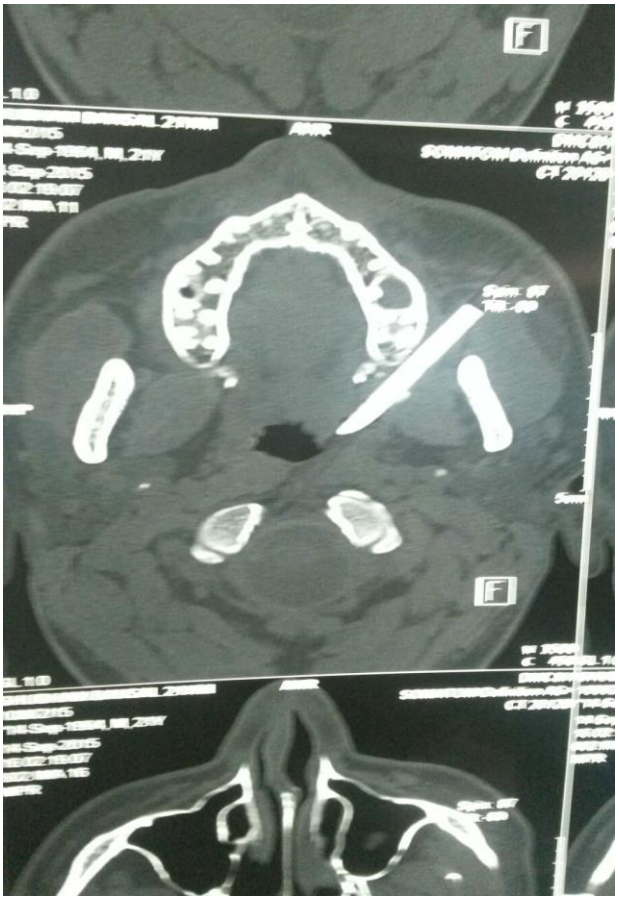


Fig 2: axial CT scan showing foreign body

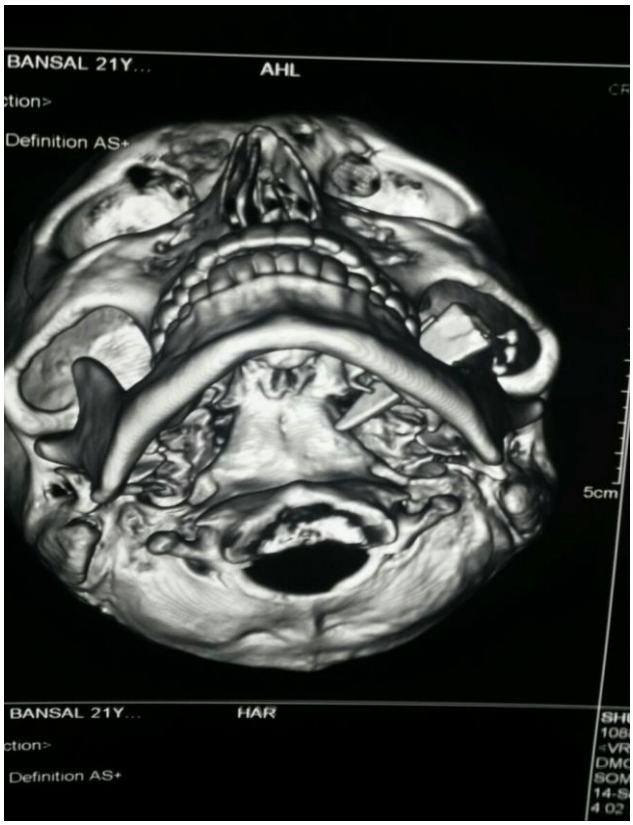
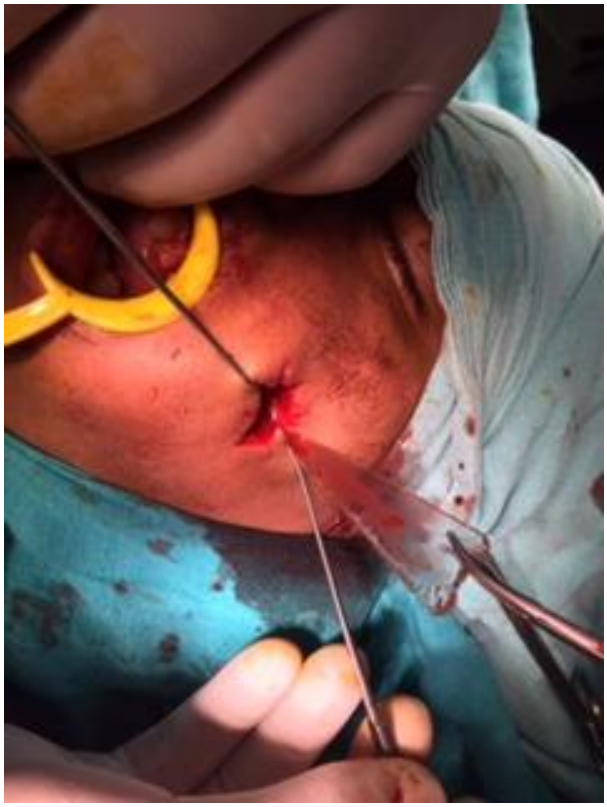
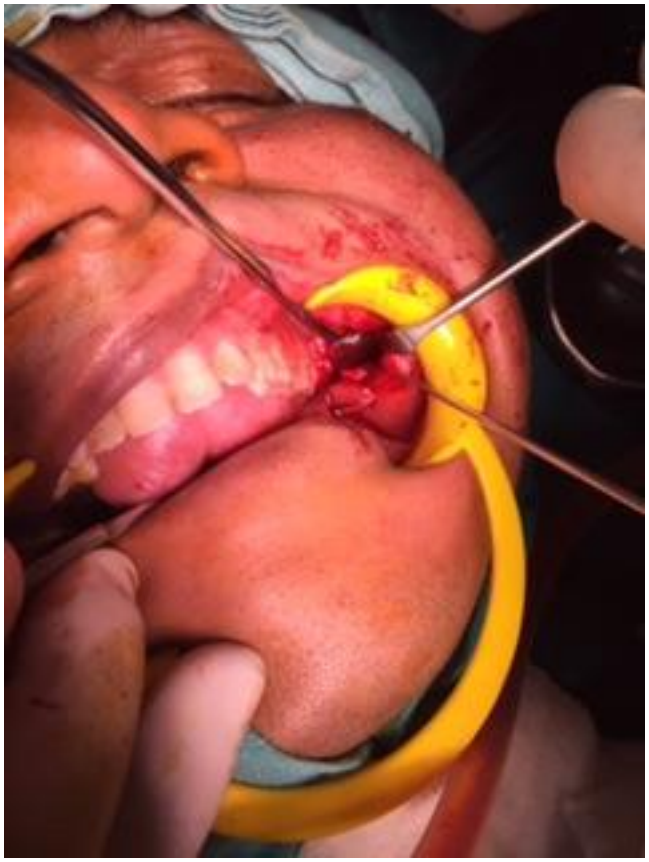


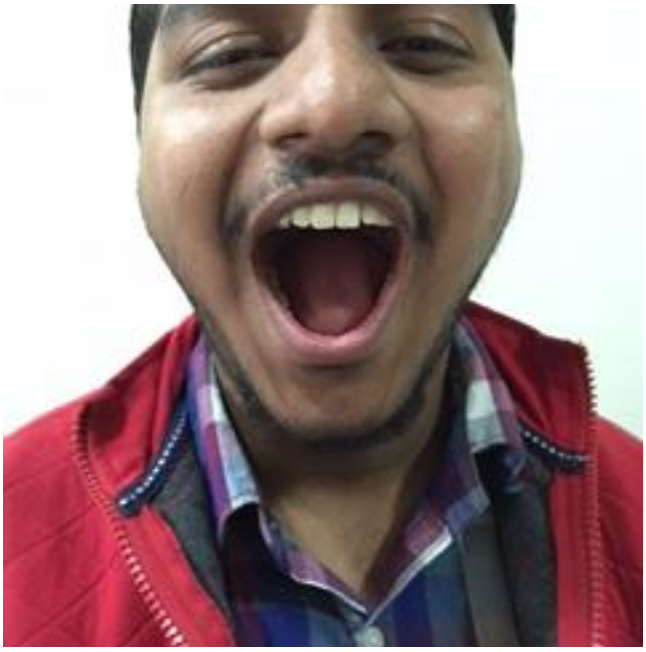
Fig 3: 3D CT showing foreign body.



Picture 1a: removed foreign body



Picture 1b: intraoral laceration



Picture 2: post-operative mouth opening

DISCUSSION

In this case, though late, but patients complaints, clinical examination and computed tomography played a major role in diagnosis. There are reports where foreign bodies like tooth brush or pencil tips accidently enter the any of the oro fascial spaces and if undiagnosed at early stage, may lead to abscess or granuloma [1]. The orofacial soft tissue spaces are potential anatomic spaces between deep fascia layers; they are bounded by bones, muscles or salivary glands and mostly filled with loose connective tissue. Foreign bodies in these spaces are usually diagnosed on plain x rays, depending on their density and the density of interface between them and soft tissue. Wooden foreign bodies are missed in these spaces [2]. In this case routine waters view for paranasal sinus radiography was not very informative and confirmative diagnosis was made on Computed Tomography. The surgical removal of foreign body can be attempted both in local as well as general anaesthesia, depending on the location (proximity to important anatomical structures) and severity (in presenting complaints) of foreign body. General anaesthesia gives a better control in case there is any unforeseen complication [3]. Timely removal of these foreign bodies is necessary to prevent complications like abscess, granuloma, necrotizing fasciitis and osteomyelitis. In acute cases, the foreign body can be pulled out of its track from entry site and the track should be thoroughly washed with betadine saline [4], as done in this case. Broad spectrum antibiotics should be administered in postoperative period and daily inspection for any signs of infection should be done.

We recommend prompt diagnosis and surgical retrieval of the foreign bodies as well as appropriate antibiotic therapy for atleast 7 days, for uneventful postoperative recovery. Accurate anatomical localization of foreign body with respect to important structures like nerves, vessels or ducts (as in this case) is necessary to do preoperative planning of surgical approach and management.

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