

Case report

A missed periorbital foreign body

Abstract

Trauma involving the eye, orbital and periorbital regions are commonly seen in cases of road traffic accidents, sports injuries and physical assaults, but cases of intraorbital / periorbital foreign bodies are rare. Early presentation, history of trauma, and imaging help in diagnosis. However, sometimes the diagnosis is missed, particularly in cases with late presentation and a vague history of minor trauma and trauma with a non-metallic foreign body. A missed foreign body may present later with infection, repeated inflammation, ptosis, and proptosis and motility defect, further complicating the management.

Here, we present a case of missed foreign body during the primary repair of facial injury in a 32-year male with polytrauma sustained in a road traffic accident. Evidence of foreign body was reported in a CT scan head advised for head injury. Re-exploration of wound and removal of foreign body is performed under local anaesthesia.

Key words:

Orbital trauma, foreign body, periorbital foreign body, metallic foreign body

1. INTRODUCTION

Road traffic accidents are on the rise due to the increase in road transport vehicles, and well-known causes of ocular morbidity and blindness resulting from injuries. Ocular, orbital and periorbital trauma are commonly seen in cases of road traffic accidents with facial and head injuries. However, cases of intraorbital / periorbital foreign bodies are rare. A retrospective study in 1061 patients with maxillofacial injury underwent maxillofacial multi slice CT scan; 250 patients (23.56%) were identified with orbital injuries: 149 (14.0%) suffered from isolated orbital fractures, while three patients had intraorbital foreign bodies lodged in extraocular muscles, the optic nerve, and within the globe.[1] Periorbital foreign bodies are rarely reported in the literature as case reports [2, 3].

The diagnosis and management of orbital foreign body (FB) may be a challenge particularly in cases with late presentation and a vague history of minor trauma. A missed foreign body may present later with infection, repeated inflammation, ptosis, and proptosis and motility defect, further complicating the management. Here we present a case of missed foreign body during the primary repair of facial injury in a 32-year male with polytrauma sustained in a road traffic accident.

2. CASE PRESENTATION

A 32-year-old male referred to eye OPD with suspected periorbital foreign body in right eye. He had history of road traffic accident at 9 am four days back. He stated that his bike slipped when a dog suddenly came in the way. Patient was under influence of alcohol. Patient took initial treatment from primary health centre and referred to this institute for further management. There was history of ear bleed and pain in shoulder. There was no history of loss of consciousness, headache, vomiting, chest or abdominal pain and breathlessness. In emergency clinic periorbital and facial lacerations were sutured. Patient was advised X-ray head, chest and spine; and CT scan head. X-ray head reported a radio opaque density in periorbital area suggestive of foreign body, more clearly seen in lateral view (Figure 1 a, b).

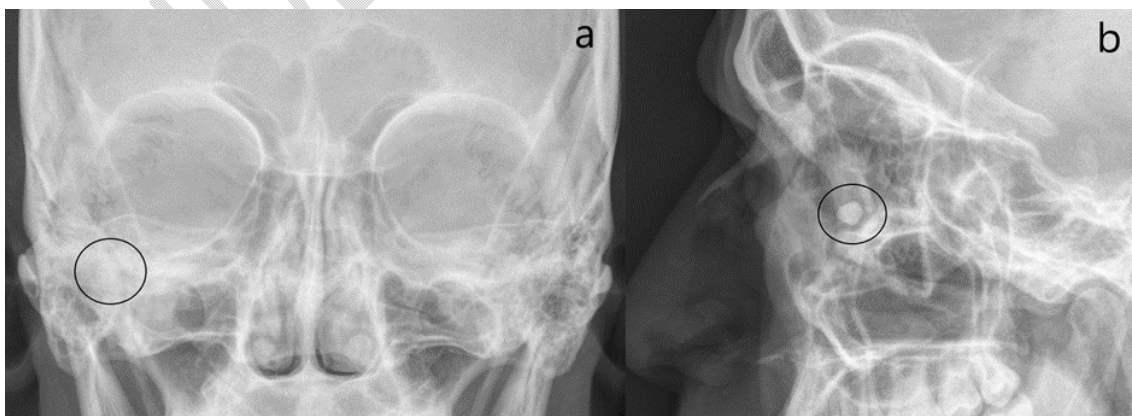


Figure 1: X-ray Orbit showing foreign body in right orbit (a) AP (b) Right Lateral view.

CT head showed evidence of soft tissue injury involving right periorbital tissues with a well-defined hyperdensity approximately 6 x 6 mm in size with perifocal oedema in preseptal region likely a foreign body (Figure 2). There was evidence of few haemorrhagic contusions and minimal subarachnoid haemorrhage in left temporal region with subtle perifocal oedema. There was longitudinal fracture of right mastoid part of temporal bone associated with hemotympanum and partial opacification of mastoid air cells. Un-displaced fracture of floor of orbit on right side with minimal pneumo-orbit was noted. Patient was referred to eye OPD after primary repair by maxillofacial surgeon and treatment from neurology and ENT department.

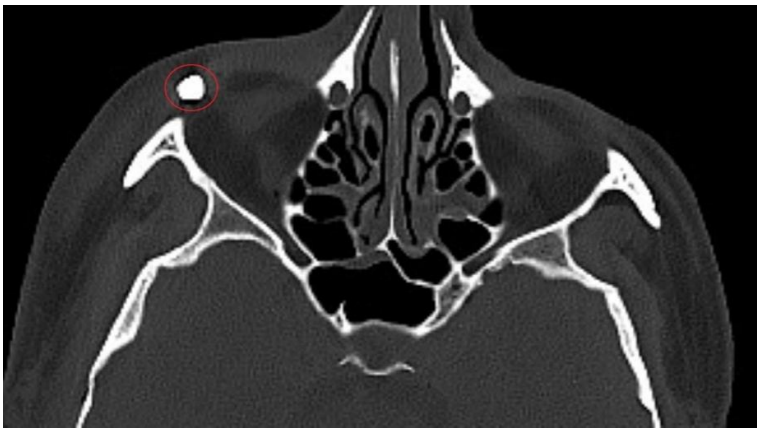


Figure 2: Non- contrast axial CT image showing a well-defined hyperdense foreign body

Ocular examination showed a mild diffuse swelling in temporal lower periorbital area around the stitched wound. Palpation revealed a hard swelling with ill-defined margins. Exploration of wound and removal of foreign body was planned under local anaesthesia. The wound was reopened, foreign body identified beneath the muscle layer was exposed and removed through blunt dissection of orbicularis muscle. It was piece of stone used for road and building construction (Figure 3).



Figure 3: A stone foreign body

3. DISCUSSION

The orbital foreign body may be associated with serious injuries as well as minor injuries. If patients present early, with clinical suspicion and help of imaging it may be easily diagnosed like in this case. However, the diagnosis and management of orbital foreign body may be a challenge particularly in cases with late presentation and a vague history of minor trauma. A retained intraorbital / periorbital foreign body commonly present with the signs of orbital cellulitis (swelling, pain, and abscess), orbital hematoma, optic atrophy, motility defect, proptosis, visual field loss etc.

The reasons for missed diagnosis of orbital foreign bodies include a vague history, especially in children and intoxicated patients who are unable to describe details of the circumstances, type of injury, and injury objects; and diverse imaging findings of different foreign body materials, such as small FB and nonmetal foreign bodies that lack typical imaging findings. During emergency management, doctors often concentrate on suturing the lacerations and securing the wound, which also results in missed diagnosis, like in this case, the foreign body was missed during primary closure of lacerations. This patient was a case of polytrauma with head and facial injury subsequently had a CT scan head following primary management, which revealed the presence of FB at an early stage and was managed promptly. A missed foreign body has been reported to be present later on after variable time (days to several months) with infection, repeated inflammation, ptosis, and proptosis and motility defect further complicating the management. [4, 5]

Radiological imaging helps in the detection and localization of the foreign body, assessment of consistency and size of foreign body and evaluation of the response of surrounding orbital tissue. Plain radiography is easily accessible and widely used to detect orbital foreign body. It may be useful in identifying and locating the metal and glass foreign bodies; however, the detection rate for organic material, such as wood, is low [6, 7]. CT scanning is considered the standard imaging technique in cases of suspected foreign body and orbital fracture [8]. It is highly sensitive and specific for detection of foreign bodies, provides precise anatomic localisation of foreign body compared to a plain radiograph. However, CT scans may produce false-negative findings, particularly if the size of the foreign body is less than 0.5 mm, and especially in the case of wooden objects [9,10].

Ultrasonography is able to detect and localize superficial foreign bodies with low radiopacity in the tissues of the body more effectively than CT and conventional plain radiography [9, 11]. It can be used to detect wood and plastic orbital FBs where X-ray and CT imaging may fail [12, 13]. MRI is useful to detect organic FBs if metallic foreign bodies are ruled out. It can detect radiolucent objects lodged in deeper tissues that are inaccessible to ultrasound scanning [14].

Management of retained intra/ periorbital foreign body is individualized. Many factors present a diagnostic and therapeutic challenge, such as the size and nature of the object, difficulty of access, and proximity of the foreign body to vital structures [15-17]. Retention of organic FB has a much higher rate of infection and inflammation than nonorganic FB and should be removed in all cases. Anteriorly placed FBs can be easily removed and should be

removed in all cases. The removal of metallic foreign bodies allows patients to undergo MRI scanning if required in the future. Posteriorly located foreign bodies have an increased risk of motility disturbances or optic neuropathy after surgical removal. Nonorganic inert FBs located more posteriorly without any clinical features may be left under observation [15]. Nonorganic Metallic compounds containing copper, iron, and lead may cause further complications[18]. Copper can incite intense inflammatory reaction therefore should be removed. Iron may cause siderosis with loss of vision, if not removed the patient should be monitored for photoreceptor function with electroretinography [17]. Although lead pellets may cause systemic toxicity; this is unlikely in cases of orbital FB[19].

4. CONCLUSION

A careful examination of the wound site is important to look for any foreign body and should be removed before suturing the lacerations. However, an impacted foreign body should be removed after clinical examination and radiologic evaluation that helps in determination of the exact size of the object and its location relative to vital structures.

CONSENT

Written informed consent was obtained from the patient's parents.

ETHICAL APPROVAL

Not applicable

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