Longstanding Unrecognized Wooden Foreign Bodies in Oro-facial Region, Report of three Cases

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Abstract
Retention of foreign bodies in maxillofacial region following trauma are not uncommon. Various retained foreign bodies reported; are tooth fragments, root canal filling material, burs, sewing needles, broken tips of probes and elevators, wooden tooth picks, piece of glass, blades of grass, a tooth brush bristle, fish bone, hair, piece of straw or grass, portion of fingernail, spike of wheat, thorn and chicken pinfeather, surgical gauze. Some times these foreign bodies get infected and spontaneously come out through draining sinus. But very rarely it is possible that some might remain in the soft tissue and go unnoticed, causing persistent pus discharge, trismus, granuloma and osteomyelitis. This article describes three cases of retained wooden foreign bodies in cheek, parotid gland and tongue with their diagnosis and management.

Keywords: wooden foreign bodies, draining sinuses, parotid fistula

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1. Introduction

Soft tissue injuries of head and neck are very common following any trauma, as face is the most exposed part of the human body. During course of trauma it is possible that various radio opaque foreign bodies like tooth fragments [20], root canal filling material, burs, sewing needles [3], broken tips of probes and elevators. [11] Various radio lucent foreign bodies like wooden tooth picks [8,10], piece of glass, blades of grass [5], tooth brush head [21] a tooth brush bristle, fish bone, hair, piece of straw or grass, portion of fingernail, spike of wheat, thorn and chicken pinfeather [3,8,10], might get entangled within the soft tissue, either in the lacerated wounds or in the soft tissue pockets. Generally these foreign bodies are removed prior to repair of soft tissue. But very rarely it is possible that some might remain in the soft tissue and go unnoticed.

These case reports describe similar cases where wooden foreign bodies were retained in the right cheek of a ten year old boy, left parotid gland of five years old boy and tongue of a forty year old man following fall from tree. The most common signs and symptoms of retention of any foreign body in maxillofacial region; are either swelling with pus discharging sinuses, trismus, sloughing of soft tissue or granuloma [18]. Exploration with debridement of wound gives the best results in these cases.

2. Case 1

A ten year old boy was referred to Maxillofacial Surgery with the complaint of persistent swelling in the right cheek region with discharge of pus. The history revealed that one and half month ago, the child had slipped and fallen from the mango tree, following which there was a penetrating wound in the right cheek which bleed profusely. He was immediately taken to near by Hospital where preliminary treatment was given after ruling out fracture of any facial bones or damage to other facial structures.

Initially the healing was uneventful but one month later parent’s noticed a swelling on right cheek which was gradually increasing in size with pain and partial restriction in mouth opening. Patient reported back to the hospital where he was put on course of antibiotics, with no further improvement in the condition. Subsequently patient was referred to our institution, with a diffused swelling on the right side of the cheek and discharging sinus within the swelling. Routine radiographs did not reveal any pathology or presence of foreign body within the wound. It was decided to surgically explore the wound under sedation with local anesthesia. During the surgical exploration, three pieces of wood deep inside the soft tissue pocket were removed (Figure 1).
Figure 1. Three pieces of wood were removed from soft tissue pocket.

The wood pieces put together was measuring about 28 mm in length. After removing foreign body, the wound was explored for any further foreign bodies and proper debridement was performed to remove unhealthy granulation tissue. Since there was a large collection of granulation tissue and long-standing infection, it was decided to keep wound open, to allow healing by secondary intention.

The postoperative sequel was uneventful and wound healed within period of one week. One-year follow up did not show any uneventful healing except patient had mild degree of scarring at wound site (Figure 2).

3. Case 2

A five year-old boy was referred to our clinic with the complain of swelling on left side of cheek since 4 days. Patient’s father gave history that the child has fallen down from tree while playing. Following which there was cut wound in left cheek measuring about 2cms and this was caused by penetrating wood. The child was taken to near by hospital where the debridement of wound and closure was done after removing wooden foreign body. Upon examination patient had discharge of pus, thinking it is an infected hematoma evacuation of hematoma was done through same cut wound and patient continued antibiotics and regular dressing for one week.

Initially the healing was uneventful. Two weeks later patient came back with parents complaining of swelling on left cheek which was gradually increasing in size with pain and pus discharge from the wound. Upon examination there was pus discharge from fistula in cheek fallowed by blood and clear fluid. (Figure 3) Intra orally clear discharge of saliva through Steson’s duct was noticed.

Figure 2. Uneventful healing with mild degree of scarring

The wound debridement was done under local anesthesia and was put on course of antibiotics, patient came back to hospital after one month with no further improvement in the condition. Subsequently patient was subjected to ultrasound of left parotid gland (Figure 4).

Figure 4. Ultrasound showing hyperechoic shadow measuring 14 mm inside the collection suggestive of foreign body

The ultrasound report revealed there was collection seen in the left parotid region measuring about 27 mm X 8 mm with sinus tract connected with skin a hyperechoic shadow measuring 14 mm was seen inside the collection suggestive of foreign body.

It was decided to surgically explore the wound under general anesthesia. During the surgical exploration, a piece of wood deep inside the soft tissue pocket was removed measuring about 14 mm (Figure 5).

Figure 5. Wooden foreign body removed from parotid gland
Since there was a large collection of granulation tissue and long-standing infection, and discharge of saliva it was decided to keep wound open, to allow healing by secondary intention. Post-operative healing was uneventful.

4. Case 3

A forty year male patient reported to Maxillofacial Surgery complaining of pus discharge from tongue since two years. Past history revealed patient had trauma, while climbing a coconut tree due to fall of a branch of the same tree. After which he had facial lacerations for which he took treatment at local hospital. Two months later patient had noticed pus discharge from the left lateral side of tongue.

He was operated twice elsewhere without succession of primary complain. Examination of tongue with application of dye, revealed three sinuses on left lateral side on dorsum of tongue (Figure 6).

![Figure 6. Three sinuses are seen on lateral side of tongue after application of dye](image)

Routine radiographs and CT scans did not reveal any foreign body. Ultra sound of tongue revealed some unusual thin mass deep in tongue muscles. Exploration and debridement of sinus was planned under general anesthesia. During surgery on deep exploration two pieces of bark of coconut tree from deep muscle of tongue measuring about 25 mm in length were removed (Figure 7).

The sinus lining was curetted, debridement of wound was done, primary closure was achieved with uneventful healing.

5. Discussion

Foreign bodies present a diagnostic challenge to even the experienced surgeon. In one review of 200 surgical cases involving retained foreign bodies, one-third of the cases had been initially missed. Wooden foreign bodies in particular pose a challenge to the physician, only 15% of wooden foreign bodies were well visualized on plain radiographs [16].

Small lacerations and penetrating wounds of the face are often associated with retained foreign bodies in the soft tissue that may not be detected during the initial examination [5,10] or history suggestive of foreign body may be absent [7,17]. In such cases 'biological' material, wood possesses a great potential for late complication such as cervical abscess, draining fistula of cheek, parotid fistula, osteomyelitis, bone destruction, granuloma, trismus [14] paresthesia of adjoining nerves [12] major vascular thrombosis, cavernous sinus thrombosis, brain abscess [15] and death have been reported [5,6, 8,10].

The factors responsible for retention of foreign bodies in soft tissue following injuries are; the face and tongue has an ability to accommodate large foreign bodies, without disturbing function and contour. Diagnosis and localization may be confirmed with plain radiographs and tomograms, if the foreign body is metallic, but in case of deeply positioned radiolucent objects like glass [5], wood and plastic etc may remain undetected. Immediately after trauma CT-scan is usually performed in cases where foreign bodies are suspected. But it is well known that a wooden foreign body can initially present as hypodenced on CT-scan and consequently be diagnosed as air [15,16] or fat [19]. However, early CT has some limitations in evaluating suspected retained foreign bodies. Vascular injuries, small foreign bodies [5], and objects with densities similar to surrounding tissues present difficulties in CT evaluation [6]. In movable structures like tongue sonography is much useful.

The facial soft tissue tends to close around the retained foreign body in small penetrating wounds. The rate of retention is higher in children because it may not be possible to obtain an adequate history of injury and profound clinical examination. These foreign bodies can occasionally harm salivary glands producing facial nerve palsy [12] cutaneous fistula if they are in parotid gland.

Most objects are superficially embraded and hence removed by the patients or parents in case of child or by the general practitioner. [7] If initially; radiologically missed or misdiagnosed, the appropriate trauma setting a penetrating wooden body must always be considered. Superficially retained wooden foreign bodies can be most reliably detected with ultrasonography if they are not
observed by palpation of soft tissue should be done to search FB. One should also explore the existing wound with curved artery forceps. Another type of calcification may occur in the presence of a foreign object over a long period and can be detected in CT [1,9,13,15]. Calcifications may be observed in the surrounding tissues as its density increases, and it may not be detected macroscopically. Wooden foreign bodies may absorb water and lymphatic from the surrounding tissues, making them more noticeable. The density of wood increases after forty eight hours, and its appearance changes. This change can be detected in CT scans [1,9,13,15].

LA: Local Anaesthesia.
GA: General Anaesthesia.

In most of the case reports including our, an attempt is made to remove the visible FB by patients, parents or primary treating physicians. The wooden FB might break during removal or at the time of trauma itself, hence requiring careful examination including deep bimanual palpation of soft tissue should be done to search FB. One should also explore the existing wound with curved artery forceps or use ultrasound for survey. The foreign body should be expected unless proven otherwise.

This article emphasizes the necessity for careful assessment of penetrating facial wounds, no matter how small they may appear. In all penetrating wounds suspected FB, are highly contaminated with organic matters and microorganisms due to soil. In order to prevent further complication caused by retained FB, it is necessary to perform a thorough examination including palpation, exploration, and imaging. The retained FB might cause a secondary infection, which can be detected by clinical examination, imaging, and metal detector. This article emphasizes the necessity for careful assessment of penetrating facial wounds, no matter how small they may appear. In all penetrating wounds suspected FB, the foreign body might be deeply embedded in the surrounding tissue, making it difficult to detect. The retained FB might cause a secondary infection, which can be detected by clinical examination, imaging, and metal detector. This fact explains why the failure to detect the wooden foreign body in spite of several surgical interventions. This also emphasizes the need for performing an ultrasound as a preferred imaging modality for detection of wooden foreign bodies in soft tissues [1].

**Summary:** Table 1 showing various long standing FBs in maxillofacial region

| Sl. No | Authors | Chief complain | Lag period | Diagnostic methods | Type of FB |
|--------|---------|----------------|------------|--------------------|------------|
| 1      | Aulkuck et al [1] | Sinus of the right cheek | Fall from a bicycle | Ultrasound | Wooden splinter |
| 2      | Akkiner M et al [12] | Severe infection of orbit | Self-inflicted injury | Magnetic resonance imaging | Wooden piece 55 X 6 mm |
| 3      | Soubhia A. et al [2] | Swelling in the incisive papilla | Traumatic laceration of the incisive papilla with a toothpick | Calfried mass examined under Electron Microscope after removal | Piece of wood 1 cm |
| 4      | Basile N Landis et al [2] | Neck mass without other signs and symptoms | Unknown | Surgical exploration under GA | Blade of grass |
| 5      | Robinson P D. et al [14] | Persistent and distressing symptoms on face | Unknown | Radiological identification | Wooden foreign body |
| 6      | Siegfried et al [15] | Pain and swelling in retromaxillary space | Unknown | Surgical exploration | Wooden foreign body |
| 7      | Woolley et al [16] | Diffusely enhanced left parotid gland | Unknown | CT scan | 1.7 cm metallic wire |
| 8      | Anne Vikram et al [17] | Extra oral swelling with pus discharge and trismus | Road traffic accident | CT scan | A wooden piece 3 X 1 cm |
| 9      | Sripathi Rao BH et al [18] | Pain and swelling in upper right lip and cheek | Road traffic accident | Surgical exploration | A wooden piece 3.2 X 0.5 cm |
| 10     | Rudgi BM et al [23] | Pain and swelling right infraorbital area | Fall from a motor icycle | Surgical exploration | Thorn 3X0.2 cms |
| 11     | Manoel Leal Filho et al [24] | Puffiness and limitation in right eye movement | Hit by branch of tree | CT scan | A wooden fragment 2 X 0.3 cms |
| 12     | SB Arengesola et al [21] | Painful right cheek swelling with trismus | Fell off his motorcycle into a ditch containing wooden sticks | Exploration under LA | wooden stick, measuring 2.5 cm by 6.5 cm |
| 13     | Mohanavalli David et al [20] | Discharge from right angle | Accident 6 months earlier | Exploration under GA | A wooden fragment 3 X 3 cm |
| 14     | Sanadi saidj et al (present report) | 1) Swelling and pus discharge | Fallen from mango tree. | Exploration under LA | 3 wooden fragments of 28 mm. |

In most of the case reports including our, an attempt is made to remove the visible FB by patients, parents or primary treating physicians. The wooden FB might break during removal or at the time of trauma itself, hence through clinical examination including deep bimanual palpation of soft tissue should be done to search FB. One should also explore the existing wound with curved artery forceps or use ultrasound for survey. The foreign body should be expected unless proven otherwise.

1) commenting on the prophylactic tetanus status: In all penetrating wounds suspected FB, are highly contaminated with organic matters and microorganisms in spore form, patients prophylactic tetanus should be considered. Long-term follow-up is also necessary, even if patient remains asymptomatic to prevent further complication caused by retained FB.

2) commenting that physical examination should include deep palpation of soft tissue in order to feel such large
pieces in the face ... and that might be a message to the ER team whom missed that ...

In most of the case reports including our, attempt is made to remove the visible FB by patients, parents or primary treating physicians. The wooden FB might brake during removal or at the time of trauma itself, hence through clinical examination including deep bimanual palpation of soft tissue should be done to search FB. One should also explore the existing wound with curved artery forceps or use ultrasound for survey. The foreign body should be expected unless proven otherwise. This article emphasizes the necessity for careful assessment of penetrating facial wounds, no matter how small they may appear.

Statement of Competing Interests

The authors have no competing interests.

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