was limited to early steroid therapy and occlusion therapy. The prognosis of oculomotor nerve palsy varies according to its etiology and the associated neurological problems. Some authors suggest waiting for at least six months before strabismus surgery, which permits the cause of oculomotor palsy to be evaluated and allows for possible spontaneous recovery [2]. A surgical approach, including strabismus surgery and ptosis surgery, should be considered according to the degree of recovery. We suggest that plastic surgeons keep in mind that facial trauma may occur in combination with various cranial nerve injuries and therefore should evaluate patients with facial trauma for the symptoms and signs of cranial nerve injuries.

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and swelling were observed around the mass. Communication was difficult due to the patient’s status of hydrocephalus; however, avoidance of palpation indicated possible tenderness near the mass. The patient’s initial white blood cell, C-reactive protein, erythrocyte sedimentation rate lab, and a plain radiograph showed no specific finding. Ultrasonography showed a small abscess in the left mandibular angle. Computed tomography angiography was performed for further evaluation and combined osteomyelitis and an abscess with osteophytes surrounding the mandible were suspected. Despite treatment with medication, the patient showed no improvement. Therefore, our department took the next step, resection of the osteomyelitic lesion with minor abscesses. Under general anesthesia, the patient was placed in a supine position. His previous operation site allowed an approach to the mandible, where the lesion was located. Partial division of the masseter muscle also allowed an approach to the mandible. The mass was composed of infected soft tissue and granulation tissue (Fig. 2). Some serous discharge and degradation parts of the implant were observed on the cortical bone. Swab culture and tissue biopsy was performed. There was no sign of osteomyelitis and cortical bone integrity was observed, therefore, bone resection was unnecessary. Finally, irrigation was performed followed by drain insertion and layer by layer suture. The drain was removed on postoperative day (POD) #2, leaving no sign of skin complication. On POD #5, vancomycin was applied due to the positive MRSA result from wound culture. Tissue biopsy showed some macrophages containing granulation tissue (Fig. 3). The patient had no abnormal lab results during the admission period. Two weeks after surgery, the patient had made a full recovery, and has remained in good health.

Biodegradable plate and screw are often used in craniofacial skeleton surgery. Polyglycolide, developed by Dexon in 1970, is the first absorbable fixation to be synthesized, followed by PDS, vicryl. Absorbable fixation is currently used successfully [3], with materials based on lactic, glycolic acid. Superior material is helpful in maintaining strength of surrounding tissues, thereby preventing inflammation, toxic effect, and carcinogenic response until the wound is completely healed. Degradation of the absorbable material is influenced by many factors. For example, size of implant, type of material, characteristics of insertion location of materials, vascularity of the tissue surrounding implantation, age, general health, etc. There are two degradation phases, phase I (hydrolysis) and phase II. Phase I is an active degradation phase as contact with water is initiated. Phase II involves conversion of debridement into CO₂, H₂O by macrophages, and initiation of the tricarboxylic acid cycle metabolism. Balance of hydrolysis and metabolism is important, due to the fact that if the amount of hydrolysis product exceeds the amount of metabolism, inflammation will occur. In this case, it is thought that infection resulted from a remnant of previous wound tissue and absorbable fixators. Complete absorption of absorbable fixators could take more than 12 months [4]. During that period, infection at absorbable fixators is possible. A degraded absorbable fixator acts like a culture medium of microbium.

According to research reported by Laughlin et al. [5], neither infection rate nor revision rate was higher for patients with a mandible fracture who underwent an operation using an absorbable plate, compared to metal fixation. Out of 50 patients with a mandible fracture, 6% had infection, 4% with hardware removal. In the control group described in the review article, out of 617 patients, 3.9% had nonunion/fibrous union, 13% with infection, and 18.9% had hardware removal. Accordingly, regular follow up is essential for use of absorbable fixators in patients. Infection is the most important and considerable
Cutaneous Fusariosis in Unprotected Snake Bite Wound of Farmer’s Hand

Eun Taik Son1, Hwan Jun Choi1, Young Man Lee1, Jun Hyuk Kim1, Doo Hyun Nam1, Hyun Deuk Cho2

Departments of 1Plastic and Reconstructive Surgery and 2Pathology, Soonchunhyang University College of Medicine, Cheonan, Korea

Correspondence: Hwan Jun Choi
Department of Plastic and Reconstructive Surgery, Soonchunhyang University, College of Medicine, 31 Suncheonhyang 6-gil, Dongnam-gu, Cheonan 330-721, Korea
Tel: +82-41-570-2195, Fax: +82-41-574-6133, E-mail: medi619@hanmail.net

This work was supported by the Soonchunhyang University Research Fund.

No potential conflict of interest relevant to this article was reported.

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The genus Fusarium is widespread in soil, plants, and the air, and broad manifestations of human disease...