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Intraorbital hemorrhage following a secondary intervention at integrated zygomatic implants: A case report

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ABSTRACT

INTRODUCTION: Zygomatic implant placement can be the best option for restoring masticatory function of an extremely atrophic upper jaw, but the procedure is more invasive than conventional implant placement and can be associated with complications.

PRESENTATION OF CASE: We report a complication that occurred during a secondary corrective surgical procedure four years after zygomatic implant placement. The patient was a 54-year-old female who had been edentulous for 25 years. Four zygomatic implants were placed. Subsequent prosthetic rehabilitation was successful. Four years later, the patient complained of discomfort. It was found that the tips of the implants on the right side were subcutaneously palpable and surrounded by granulomatous tissue. Intraoral surgery was performed to remove the protruding tips of the two implants. Post-operatively, the patient developed severe orbital pain on the right side with proptosis and diffuse swelling of the eyelids. Emergency surgery was performed to drain the intraorbital hemorrhage. The patient healed uneventfully without loss of visual acuity.

DISCUSSION: Scarce prior reports describe trauma to the orbit during zygomatic implant surgery, mostly involving orbital penetration during zygoma implant placement. To our knowledge, the present case report is the first to describe an intraorbital hemorrhage that led to an orbital compression syndrome necessitating emergency surgery.

CONCLUSION: In our case, corrective surgery in a patient with zygomatic implants resulted in an intraorbital hemorrhage, followed by an orbital compression syndrome. Emergency surgery was immediately performed, allowing hematoma drainage and eliminating compression of the intraorbital content. Symptoms quickly resolved and eyesight was not compromised.

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1. Introduction

Zygomatic implants offer an additional treatment option for restoring masticatory function of an extremely atrophic upper jaw, and can potentially also improve facial appearance. The use of zygomatic implants may serve as a valid alternative to sinus augmentations or onlay bone grafts, followed by dental implant placement. Compared to the placement of conventional dental implants, the installation of zygomatic implants is a more invasive procedure, but it may be the best or only option in cases where bone reconstructive options are contra-indicated or unwanted by the patient [1,2].

Zygomatic implants have a high success rate, with reported cumulative survival rates of 96.3–100% [1–5]. The literature

includes reports of zygomatic implants being associated with several types of complications, including persistent infection of the maxillary sinus in up to 21.4% of procedures [2–5], buccosinus fistula, infection around the implants, chronic gingivitis, and infraorbital nerve damage [2,5,6,11]. Implant penetration into the nasal cavity or even intracerebral penetration have also been described [1,3,7].

Here we report a case in which intraorbital hemorrhage occurred following surgery to correct protruding tips of zygomatic implants, four years after initial implant placement. This case report is in line with the SCARE criteria [8].

2. Presentation of case

A 54-year-old Caucasian female presented at the Department of Oral and Maxillofacial Surgery at our institute. The patient was healthy, and did not smoke or consume large amounts of alcohol. She only suffered from hypothyroidism, treated with levothyroxine 125 µg once daily.

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Fig. 1. PA radiograph pre-treatment. Note that there are no abnormalities of the orbits.

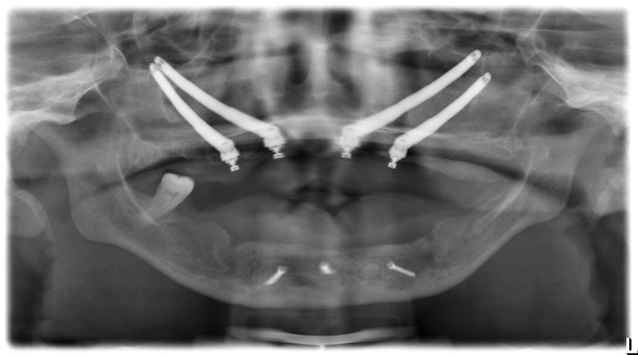


Fig. 2. Panoramic radiograph showing the placement of four zygomatic implants and onlay graft.

The patient had been edentulous in the upper jaw for more than 25 years. Several removable prostheses had been fabricated for her over this time, but there was a lack of retention due to severe atrophy of the jaw. PA radiograph showed no other abnormalities (Fig. 1). It was decided to place four zygomatic implants to improve stability and function, while simultaneously removing teeth in the lower jaw due to advanced periodontitis, and performing a bone graft procedure in the mandible using corticospungious bone graft from the anterior iliac crest (Fig. 2).

Surgery was uneventful. Four zygomatic fixtures were placed into the zygomatic bone, and the patient was discharged from the hospital the following day. Healing went well, and prosthetic rehabilitation of the upper jaw was conducted using a removable overdenture. A temporary removable prosthesis was made for the lower jaw. Treatment resulted in improved masticatory function and esthetics.

Four years later, the patient returned to our department complaining of a protrusion in the region of the zygomatic bone on the right side. This protrusion caused chronic irritation and pain

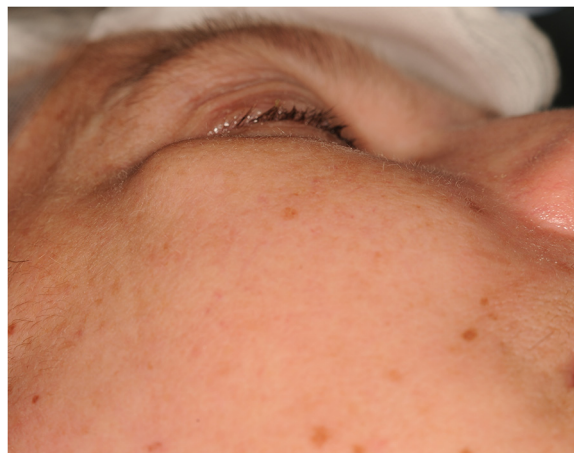


Fig. 3. Clinical photograph showing the protrusion at the zygoma on the right side.



Fig. 4. Extensive swelling of the eyelid and proptosis, frontal view.

in the overlying skin. Examination revealed that these symptoms were caused by protruding tips of the apical part of the two zygomatic implants on the right side, which were surrounded by chronic granulomatous tissue (Fig. 3).

It was decided to perform exploratory surgery of the area, and to shorten these zygomatic implants under general anesthesia on an outpatient basis. Although the top of the zygoma is a difficult region to visualize from an intra-oral approach, surgery went as expected. We observed that at this time (four years after implantation), the implants protruded 3–5 mm past the outer border of the zygoma. Most likely, a low-grade infection at the tips caused resorption of the zygomatic bone. A 3-mm-diameter round drill was used to mechanically remove the overhang of both implants until no more irregularities were observed. The operating field was copiously rinsed, and then the wound was closed using resorbable sutures. The patient recovered uneventfully from the anesthesia, and was transported to the recovery room.

About half an hour later, the patient developed severe pain at the right eye, along with diffuse swelling of the upper and lower eyelid (Fig. 4). The severity of swelling precluded clinical inspection of the eye or extensive evaluation of eyesight. A proptosis of the eyeball was observed, and the patient was still able to differentiate between light and dark. The most likely clinical explanation was a bleed in the orbit, although the precise cause was unknown. No ophthalmologist was readily available for an emergency consult. The patient was prepped for emergency surgery to decompress the orbital content. No CT scan was performed at that time.

The patient was put under general anesthesia. A lower eyelid incision was made to gain entry to the right orbit. The lower orbital rim was identified, and the orbital floor was explored. During this

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