

Dermal fat graft for retromandibular depression in salivary glands surgery

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SUMMARY

Salivary glands surgery either parotidectomy or submandibulectomy will result in significant cosmesis deficit due to retromandibular depression postoperatively. This is prominent in the setting of a large salivary gland tumour extirpation. The placement of dermal fat graft will lessen the retromandibular depression, hence enhancing post-operative cosmesis outcomes. This is a case of a 33-year-old Malay lady, presented with a history of right submandibular swelling which gradually increases over 5 years duration. There was no other significant history noted. Clinical examination revealed a 10.0 cm X 8.0 cm right submandibular mass, firm in consistency, and mobile with no other neck nodes palpable. Intraoral examination revealed that the mass was partially ballotable, with no evidence of calculi debris, discharge or inflammation seen at the left wharton duct opening. Ultrasound and fine needle aspiration cytology confirmed it was a pleomorphic adenoma of the right submandibular gland. Right submandibulectomy was performed with abdominal fat grafting. The dermal abdominal fat graft 6.0 cm x7.0 cm, was harvested using a monopolar cautery, after estimating the size of the surgical defect. Both surgical wounds were closed in 2 layers. Postoperatively, at 3 months, there was no significant retromandibular depression observed, and the patient was happy with her aesthetic outcomes. Salivary gland surgery either parotidectomy or submandibulectomy will cause significant retromandibular depression post-operatively. This impairs the cosmesis outcomes which is significant especially in the young patients who had huge tumours. Dermal fat graft has been proven to improve this facial contour defect due to the salivary gland surgery either parotidectomy or submandibulectomy. It is a versatile approach, to improve cosmesis outcomes in post salivary gland surgery. It is easy to harvest and does not cause significant extra time to the surgery.

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When the teeth bites during swallowing

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SUMMARY

Oesophageal perforation post foreign body removal rarely occurs but can lead to fatal complications. The morbidity and mortality related to oesophageal perforation is high, even higher if there is a delay in diagnosis and treatment. The ideal treatment for oesophageal perforation is still controversial between conservative and surgical management. A 44-year-old lady was referred at day two post challenging direct laryngoscopy, oesophagoscopy and foreign body removal (denture) from a nearby hospital. She developed back pain and had an episode of oxygen desaturation two days after the removal of foreign body. Chest x-ray showed a blunted right costophrenic angle. CT scan revealed mediastinitis with air pockets within the mediastinum. She was referred to the upper gastrointestinal surgical team at our centre. Oesophagogastroduodenoscopy was done which confirmed the presence of an oesophageal perforation. Neck exploration and primary repair of the oesophageal perforation was performed. Intraoperatively, there was a long linear full thickness tear over the right lateral wall of the oesophagus with communication into the right pleural cavity at the apex of pleura, measuring 4 cm in length, extending 17cm to 21cm from the incisor. There was another tear at the superficial mucosal over the anterior oesophageal wall, 20cm to 25cm from the incisor. Circumferential dissection was done towards the thoracic inlet. The perforation site muscle and mucosa was trimmed followed by suturing it in 2 layers with absorbable suture 4.0. Continuous suture was performed for the inner layer mucosa and interrupted suture for the outer layer muscle. The proximal and distal end was clipped. The sternal head of sternocleidomastoid muscle was used as a flap to enhance the upper half of the repaired site. Two chest tubes were inserted and size 15 Blake drain was inserted into posterior mediastinum. Post operatively, she was propped up 30 degree, was on nasogastric tube feeding and nil per orally. Chest x-ray post surgical repair revealed no abnormality. One week later, oral contrast study was done which showed no obvious leakage of contrast. She was allowed orally and discharged home well. On subsequent follow up, she was well and able to take a normal diet. Surgical management remains the main modality treatment for a large oesophageal perforation, but for a small perforation, it can be treated conservatively. Mortality rate related to oesophageal perforation ranges between 5% to 40%, worsen by delay diagnosis. If treated after 24 hours of injury, mortality rate can be as high as 50%. A high index of suspicion is required for early diagnosis and intervention.