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Optimization Of Surgical Tactics For Treating Patients With Midrace Trauma

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ABSTRACT

The management of midrace trauma continues to challenge maxillofacial surgeons. The complex local anatomy and functional and cosmetic importance of the region make precise surgical correction and reconstruction essential to success. The following article aims at looking for ways for treatment of the surgery.

KEYWORDS

Midrace surgery, fracture, post-traumatic deformity, inflammatory complications.

INTRODUCTION

Fractures of the lower wall of the orbit occur as in combination with damage to the bone - mid-zone target skull, and in isolation. The reasons are fractures are an increase in intraorbital pressure, as a result of which the edges of the orbit remain are intact, and its lower and dialed wall. For fractures of the lower wall orbit, there is an increase in its volume due to a change non-parameters of the maxillary sinus and walls lattice labyrinth. In this case, the paraorbital cellulose can move and penetrate into the perisinuses, which

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leads to a change in position the eyeball, impaired mobility, and when preservation of eye function - to double vision.

Diagnosis of damage to the middle zone of the face in modern conditions necessarily include beam research methods. Quite often clinical the picture with fractures of the lower wall of the orbit is it is lubricated. With a small amount of damage or as a result of post-traumatic edema in patients there may be no complaints from the organ of vision in those several weeks after injury. In some cases there are no clinical signs of a fracture. Rent genography in classical projections may not give enough information about the nature of the damage eye sockets, and underestimating the severity of the injury can lead to the development of post-traumatic deformities and persistent disorders of binocular vision.

In order to replace defects in the lower wall of the eyes women use auto- and allografts, as well as various non-biological materials. Auto trans plantations represented by the ideal scallop bones, areas of the cranial vault, antero-wall of the maxillary sinus, the supraorbital edge of the frontal bone, part of the frontal process of the upper lusty, ear cartilage, etc., have a number of advantages (low - risk of inflammatory complications - and rejection), however, there is a possibility of their desorption, fracture or displacement. It is necessary note the increase in the duration of the operation, and an increase in its trauma due to the need additional accesses. Application of all cartilage or allograft allows you to avoid creating an add the surgical field and simulate the transplant ate. The disadvantages here are the tendency material for desorption, the possibility of septic complications, it is also necessary to remember about the possibility the rate of infection with the human immunodeficiency virus and other infections.

Wide application in dental surgery received non-biological implants walking - silicone, bioactive glass, materials on based on polyethylene, metals, etc. However, not all of them possess sufficient biocompatibility, elastic stability and stability without additional fixation. There is no bone integration here, but the formation fibrous tissue on the bone-implant border does not provide a strong enough bond.

Treatment of injuries of the maxillofacial area without surgery. Patient management begins according to the ABCDE protocol (airway, airway patency; breathing, breathing; circulation, circulation; disability, neurological status; exposure, environment). To maintain airway patency, naso- or or tracheal intubation may be performed, but blind nasotracheal intubation should be performed with caution. When installing a nasotracheal tube, bleeding from the vessels of the nasal cavity or nasopharynx can be provoked; in a stunned patient with a fracture of the base of the skull, the tube may enter the cranial cavity. As in all cases of facial injuries, in case of trauma to the maxillofacial region, airway patency is ensured as quickly as possible. further increase in soft tissue edema for several hours can make intubation extremely difficult and even impossible. The need for an emergency tracheotomy is rare, with the exception of fractures of the larynx and situations in which orotracheal intubation is impossible due to severe edema or bleeding. Semi-selective tracheotomy in the operating room is performed for those patients who, due to a pronounced deficit of consciousness, severe injuries of bones and soft tissues, require prolonged intubation. In order to replenish

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the volume of circulating blood, intravenous administration of fluids is carried out; with significant blood loss, erythrocyte mass is transfused. Antibiotics are given to prevent infection, especially in patients with severe soft tissue damage or open fractures. Tetanus prophylaxis is in progress. With severe pain syndrome, analgesics are prescribed, either oral or intravenous, depending on the patient's condition. There is no consensus on the tactics of managing patients with progressive loss of vision, since it is still unclear in what cases emergency decompression of the orbit leads to an improvement in prognosis. If the eyeball is tense, lateral canthotomy and cantolysis are urgently performed to eliminate the holding force of the eyelids.

If a specific cause of the compression can be seen on CT, an urgent operative decompression is indicated. All patients are given high doses of corticosteroids; surgical methods of treatment are indicated only with progressive loss of vision. b) Surgical treatment of the maxillofacial area without surgery. Fortunately, cosmetic defects after an incomplete or poorly performed facial bone reduction are rare, but their severity can be very serious. Small cosmetic defects are quite common, however, in modern society a "good" aesthetic result is considered insufficient, and patients demand perfection from the doctor. The main reasons for the unsatisfactory result are the wrong choice of the surgical approach, intervention too early or too late, and insufficient alignment of bone fragments. Most facial fractures in adults require open reduction with internal fixation of the fragments. In some cases, for example, with fractures of the bones of the nose or lower jaw, closed reduction is sufficient.

1. Treatment of a fracture of the frontal sinus. Fractures of the anterior and posterior walls of the frontal sinus without displacement of the fragments do not require active treatment. Fractures of the anterior wall with displacement of fragments (more than half the width of the anterior wall) lead to the appearance of a cosmetic defect; therefore, bone fragments should be repositioned. Displaced fractures of the posterior wall often lead to complications: rhinoliquorrhea and / or the formation of an intracranial hematoma. In such fractures, either open reduction is used, followed by obliteration of the sinus with adipose tissue of the anterior abdominal wall, or, in the most severe cases, the posterior wall of the sinus is removed, as a result of which the brain moves into its lumen (cranialization). Fractures of the frontal sinus, combined with fractures of the walls of the frontal-nasal duct, with a high degree of probability lead to duct stenosis and subsequent mucocele formation, therefore, with these types of injury, the sinus must be obliterated. For small fractures of the anterior wall, access can be provided through existing skin defects, but most often either bicoronary or hemicoronary access is required.
2. Treatment of a fracture of the zygomatic-eye complex. The standard treatment tactics for fractures of the zygomatic-eye complex is open reduction with internal fixation of the fragments. Three-point fixation is preferable with the help of which it is possible to achieve a reliable attachment of the fragments and matching their edges. Usually, fixation is performed through the following areas: fronto-zygomatic suture (depending on

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the circumstances, use the upper or lower blepharoplastic access, or hemicoronary access); infraorbital duta (either transconjunctival or lower blepharoplastic access); zygomatic-maxillary support (access through the oral cavity, incision but transitional fold of the upper lip). For single isolated fractures of the zygomatic arch, the Gillies approach is used, soft tissues are exfoliated under the temporal fascia from the temporal fossa, after which the elevator is installed below the zygomatic arch. By definition, this approach is an open reduction of the zygomatic arch without internal fixation. In case of comminuted fractures, an open reduction with fixation of fragments is required; access to the zygomatic arch is provided through a hemi coronary incision, the tissues are exfoliated deeper than the temporoparietal fascia. Indications for surgical treatment for fractures of the bottom of the orbit are significant fractures with damage to more than 50% of the bottom of the orbit, post-traumatic enophthalmos, restriction of muscle mobility with the development of diplopia. The contents of the orbit that have descended into the maxillary sinus should be returned back, after which the lower wall plastic is performed with a bone or cartilage graft, or alloplastic material. Transconjunctival access.

3. Treatment of fracture of the naso-orbital-ethmoid complex. Fractures of the naso-orbital-ethmoid complex require open reduction with internal fixation of the fragments. In type III fractures, the severed medial tendon of the eyelids is sutured or attached with wire either to the opposite nasal bone or to a miniplate. With saddle deformity, a cartilage, bone or alloplastic graft is placed under the nasal dorsum. Access either through an existing traumatic skin incision or bicoronary.
4. Treatment of a fracture of the upper jaw (according to Le Fort). To form a normal bite, it is required to fix the upper and lower jaws with dental splints. Then, successive reduction and fixation of the fragments to the plates is performed either in the direction from the lowest fracture line to the highest one, or vice versa. The most used approaches, which allow manipulation from both sides at once, are access through the midface and access through the buccal groove.
5. Treatment of a fracture of the lower jaw. Just as with fractures of the upper jaw, in order to form a normal bite, it is necessary to fix the upper and lower jaws with dental splints. In case of non-displaced or uncomplicated fractures, for successful recovery, only fixation of the upper and lower jaws (splints, rigid fixation) is sufficient. For fractures with displacement of fragments, or with an unfavorable clinical picture, open reduction with rigid fixation is required. Mini-plates, mandibular plates, or reconstructive plates are used. A lag screw can also be used to fix the fragments. For this, holes are placed in the proximal areas of the bone, into which a standard screw can then be screwed. When the screw thread enters the distal fragment, the screw can be secured to the proximal fragment. The best option for osteosynthesis is to place a single plate along the Champy line, where the compression forces along the lower edge of the jaw are equalized by the abduction (tension) forces along the alveolar arch, but, unfortunately, in most of the lower jaw this line coincides with

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the course of the lower alveolar nerve. As an alternative method, a mini-plate can be placed on the lower edge of the jaw, and a dental metal splint is placed on the lower jaw to ensure proper tension and maximum fixation of the fragments. Previously, in subcondylar fractures, closed reduction with fixation of the jaws was most often resorted to; However, in recent years, there has been a shift in the generally accepted methods of treating such fractures, more and more often they began to resort to rigid fixation through open or endoscopic approaches. In most cases, the access is intraoral (through the gum-buccal fold), but in certain situations it is necessary to resort to open approaches (submental, submandibular, preauricular). As a rule, unstable or non-viable teeth located on the fracture line must be removed, but in all other cases, teeth, even mobile ones, should not be removed, since they are necessary to align the dentition.

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