

UNRECOGNIZED LARGE WOODEN INTRAORBITAL FOREIGN BODY**Ishan Yadav^{1,*}, Rajendra P. Maurya², Prashant Bhushan³, Mahendra K. Singh⁴,
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ABSTRACT

Intraorbital foreign bodies are relatively rare and are often associated with vision threatening complications. Their clinical presentation and treatment outcome is variable depending on the size and composition of the foreign body. Metallic and inert substances like glass and plastic are relatively well tolerated but organic foreign bodies like wood is poorly tolerated and may lead to severe inflammatory reaction and secondary infection needing prompt surgical intervention. Although identification and removal of wooden foreign bodies is very difficult, we report this case for its unusual presentation, where a large intraorbital wooden foreign body presented with a disfigured scar of right upper eye lid, two years after road traffic accident. The foreign body was removed successfully without any complications.

Keywords: *Intraorbital foreign body, wooden foreign body.*

INTRODUCTION

Intraorbital foreign bodies are usually caused by high velocity injuries such as gunshot, blast injury or projectile objects¹. They may result in severe structural and functional damage to ocular globe and adnexae². Clinical manifestations, management and prognosis of intraocular foreign body depends on its size, location and composition of the traumatic agent³. Depending on composition of the agent, foreign bodies can be divided into metallic, such as steel and iron and non-metallic like plastic and glass and organic substances like wood⁴. It is very difficult to identify and localize small, impacted wooden intraorbital foreign body, even with gold standard imaging modalities like CT scan and MRI⁵.

Management and prognosis of wooden intraorbital foreign body is usually poor because it acts as nidus for orbital infection⁶. Wooden foreign bodies often break during removal⁷. We report an interesting case of unrecognised, retained intraorbital foreign body without any complication.

CASE REPORT

A 17 year old male who had history of road traffic accident, with fall towards

right side of the face two years back, presented to our OPD with disfigured scar of right upper eye lid. After road traffic accident he was referred to a local practitioner who did only primary suturing without any imaging investigation. After few months of primary wound closure, patient complained of developing a cosmetically disfiguring scar and distorted right upper eye lid and brow. Thereafter, he remained asymptomatic and did not have any ocular complaint, but necessitated a visit to an ophthalmologist due to cosmetic factor.

The patient had full ocular examination at our hospital for his cosmetic complaint of right eye. There was notching of lid margin, entropion of the medial one third of lid and hypertrophied keloid scar of 5 mm x 5 mm, just above the notched margin. Right brow was disfigured and there was moderate traumatic ptosis [figure 1]. On palpation, a hard mass was felt just beneath the hypertrophied scar in the supranasal quadrant of right orbit. Digital X-ray and CT scan was advised to rule out any possibility of intra-orbital foreign body. X-Ray orbit did not reveal any radio-opaque foreign body but CT scan [coronal view] demonstrated a hypodense circular area [figure2] whose axial section corresponded with a hypodense subcutaneous tract of around 5 cms in length. There was no evidence of any

intracranial extension of foreign body or any damage to the medial wall of right orbit. Extra-ocular movements were slightly restricted, superior-medially. Vision in right eye was 6/9, rest ocular examination was within normal limit. After clinical and radiological examination, a decision was taken to surgically explore the foreign body and to cosmetically improve the appearance. Intraoperatively, a full thickness vertical lid splitting incision was given, originating from the notched margin and incorporating the hypertrophied scar. After carrying out fine dissection in the superior-medial aspect of

right orbit we were able to locate an impacted foreign body, which was carefully grasped by forceps and with gentle traction it was successfully removed. On examination, it was revealed to be a wooden foreign body measuring 5 cm in length. After removing the scar tissue, the wound was closed with 6-0 silk sutures. Postoperatively the patient received antibiotics for 7 days. There was no ocular restriction and post-operative visual acuity after one month was 6/9 in right eye. Ptosis correction was planned.



Figure 1: Preoperative photograph showing right eye mechanical ptosis, hypertrophied scar with notching of upper lid with disfigured right eye brow.

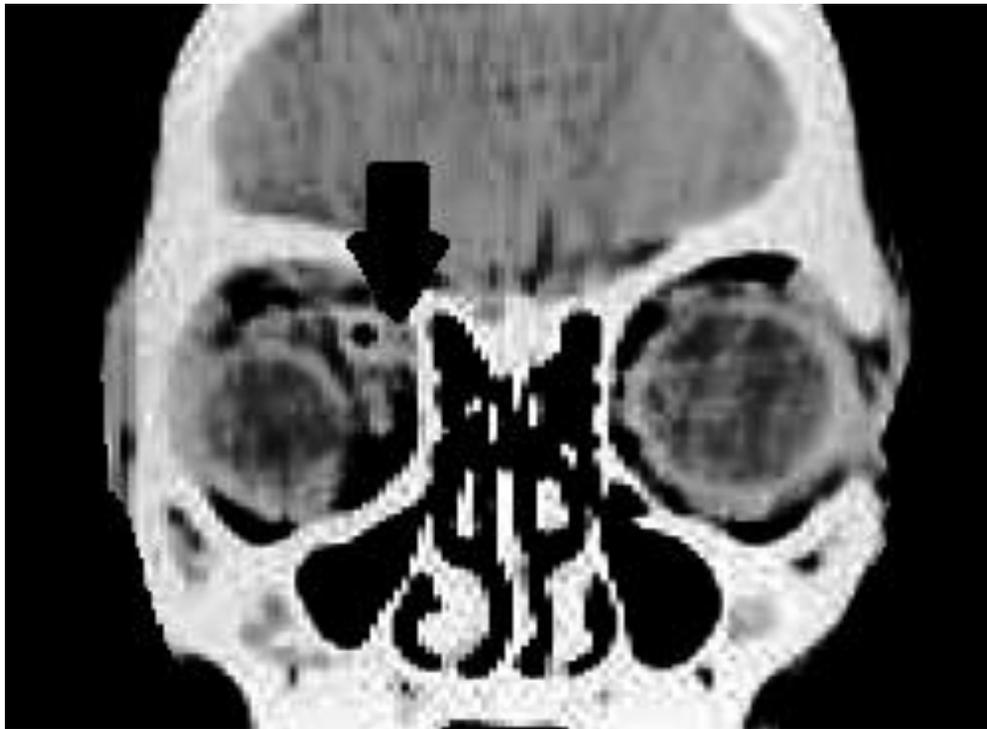


Figure 2: CT scan(coronal view) of Orbit showing hypodense shadow of foreign body in superonasal orbit.



Figure 3: Surgically removed wooden foreign body.



Figure 4: Image of the extracted wood



Figure 5: Immediate post-operative photograph.



Figure 6: Two months postoperative face photograph

DISCUSSION

Although orbital injuries with a retained foreign body are relatively rare in civilian life, they are usually caused by high velocity projectiles such as a gunshot or industrial accident/ road traffic accidents⁸. Penetrating orbital injuries with foreign body may result in severe complications, and may even be potentially fatal, since orbit provides access to the cranial cavity it can involve the meninges and central nervous system⁹. Complications usually depend on the type of injury and on the nature and location of foreign body. Orbitocranial injury and posteriorly located intraorbital foreign body have an increased risk of motility disturbance or traumatic neuropathy with trauma to ocular nerves¹⁰. Metallic and inorganic foreign bodies like glass and plastic are usually inert and thus well tolerated, if retained for longer durations. However, organic foreign bodies like wood are usually associated with severe inflammation and infection. The porous structure and organic nature of wood provides nidus and acts as an appropriate

culture media for growth of microbial agents¹¹. Thus patients of wooden intraocular foreign body may present with complications like granuloma, orbital cellulitis, abscess or discharging sinus¹².

We report this case of unnoticed intraorbital wooden foreign body without any ocular symptoms or complications one year after road traffic accidents. Identification or localization and removal of wooden intraorbital foreign body can often be technically challenging. Plain X ray is least important imaging technique for identifying wooden intraorbital foreign body as detection rate is low (0 to 15 %)¹³. CT is considered to be the gold standard to detect intraorbital foreign body but radio density of CT scan for wooden foreign body is variable and may be similar to that of orbital fat and muscle¹⁴. Wooden intraorbital foreign body shows negative Hounsfield unit due to air filled porous microstructures and water content. Hounsfield unit of wooden foreign body decreases over time. In acute stage, it mimics the orbital emphysema, and as water content dries up with increasing duration,

wood assumes moderate density and mimics orbital muscle and fat. CT scan of orbit may miss smaller wooden foreign bodies, although in such cases MRI can be advised, as it can distinguish between air and wood easily¹⁶. Previous literature reviews have suggested indications for removal of retained intraorbital foreign body, with various complications such as orbital granuloma, cellulitis and abscess. There was no such indication in our case. It was an accidental finding of retained intraorbital foreign body while patient was seeking cosmetic correction.

CONCLUSION

The possibility of retained intraocular foreign body should be highly suspected in any road traffic accident case causing orbital injuries even in cases of no ocular signs and symptoms. Appropriate imaging modalities should be used for evaluation of orbital injuries and foreign bodies. The wooden intraorbital foreign body should be removed surgically, if present.

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