Original Research Paper

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TRISMUS AND ORAL CAVITY STENOSIS AFTER CAUSTIC INGESTION: SURGICAL MANAGEMENT

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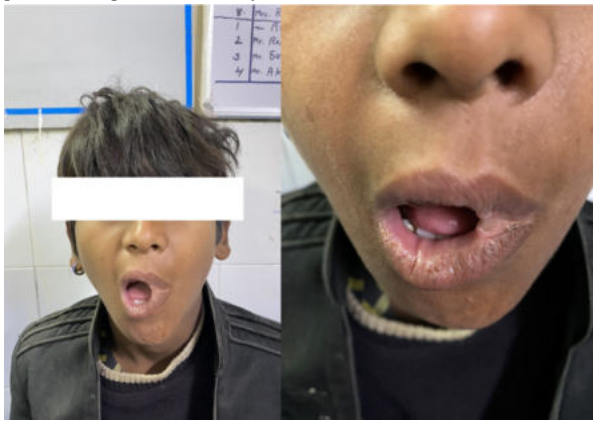
ABSTRACT Caustic ingestion in general is a Medical and a Surgical emergency and may be life threatening. The effects and clinical features are often dependent on the chemical nature of the compound ingested and, it's strength. Common scenario is usually a child or a mentally retarted person who gains access to caustic or corrosive substances usually used in household and mistakenly ingests it considering it palatable. The general signs and symptoms are burns and tissue disintegration coupled with necrosis. These changes are pronounced in oral cavity, oesophagus, and stomach. Long lasting complications are Peptic Ulcers, Esophagitis, Esopahgeal Strictures, Oral submucous fibrosis, Trismus, Stenosis, and abnormal tissue healing. We present a clinical report of a 7-year-old Male child who had a history of acid ingestion in early childhood and the surgical repair of the defect.

KEYWORDS :

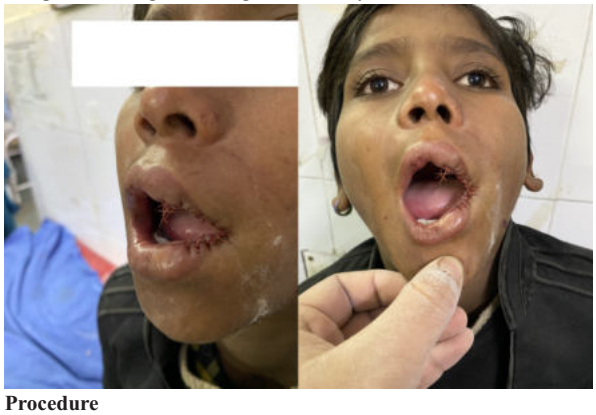
Case Presentation

A 7-year-old Male child presented in the outpatient department with a complaint of difficulty in opening mouth and inability to speak clearly due to restricted mouth opening. His general physical examination and routine Ear, Nose and Throat examination was normal except his oral examination revealed abnormal fibrosis and synechiae in between his lips and in the gingivolabial sulcus which resulted in inability to open the mouth completely and difficulty in eating and speaking. On inquiring about the deformity further the patient had a history of acid ingestion 3 years ago which is generally used in household cleaning.

The patient was admitted and all the routine investigations carried out. After thorough examination, surgery under local anaesthesia was planned to repair the deformity.



Preoperative images showing the deformity



Procedure

The surgical repair was planned under local anaesthesia and the patient was anaesthetised in the areas of upper and lower lip, gingivolabial sulcus and the surrounding buccal mucosa. After ensuring adequate local anaesthesia incisions were marked and placed surrounding the scar tissue in between the lips ensuring adequate margins and fresh edges both inside the oral cavity in gingivolabial sulcus and externally. All the scar tissue was excised and mucosal repair of the margins of the lip was done using interrupted absorbable surgical sutures. The post procedure images are shown below.

After the procedure it was noted that the mouth opening was improved immediately and the excision was done safely and appropriate repair was done using Y-V plasty in the buccal mucosa for mucosal defect repair . The patient was discharged and was followed up on once-a-week basis for 4 weeks.