

Prosthesis in sinonasal malignancy

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ABSTRACT

Facial defects may be caused by post cancer surgery, congenital or trauma with tissue loss which cannot be covered by patients due to their external exposed site. Despite advances in plastic reconstructive surgery, there are always need for maxillofacial prostheses for these patients so that they are able to come back to society. Maxillofacial prosthetic rehabilitation aims to restore anatomical function when massive tissue defects are present and in majority of the treatments provided, aesthetic is the primary factor. Maxillofacial prostheses are mainly for those who are immuno-compromised, having medical constrain or refuse to undergo more complicated reconstructive surgical procedures. Maxillofacial prosthesis can be divided into two types: internal and external prostheses. Obturator is an example of internal prostheses, which can be used as provisional or definitive rehabilitation. External prosthesis for example nasal prosthesis is more flexible and can mimic property of soft tissue. Retentive means for maxillofacial prostheses involved the use of medical-grade skin adhesive, solvents, eyeglasses, the use of soft and hard tissue undercuts and other modalities. The prostheses may also retain with osteo-integrated implants, which had been used since 1979. Sharing UKM Medical Centre experience on treating post facial cancer surgery with non-surgical facial rehabilitation with both internal and external prostheses.

The effect of hypersensitivity state on chronic iatrogenic facial nerve palsy: Universiti Kebangsaan Malaysia Medical Centre Experience

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ABSTRACT

Objectives: To review the management and discuss the outcome in patients with iatrogenic facial nerve palsy. **Materials and Methods:** Retrospective study in a tertiary centre. Twelve patients with iatrogenic facial nerve palsy (FNP) between June 1995 and June 2015 were evaluated. A review of medical records including site of injury operative procedure performed and post-operative facial nerve recovery based on House Brackmann (HB) Classification were evaluated. **Results:** Ten patients had iatrogenic complete facial nerve palsy (FNP) secondary to mastoidectomy, one FNP secondary to canalplasty and only one patient had FNP secondary to superficial parotidectomy. Of the nine cases five had concomitant profound sensorineural hearing loss and one had concomitant labyrinthine fistula. The injury of second genu was 50.0%. We postulate that the common cause for FNP following mastoidectomy was due to the surgeon failed to identify the antrum and the facial nerve landmarks. Four cases had injury to the tympanic segment and one at the mastoid segment and one at intraparotid facial nerve trunk. All the cases underwent facial nerve exploration and decompression. One case required cable graft reconstruction using sural nerve. In one case of facial nerve dehiscence, the FNP is secondary to thermal injury after the surgeon use unipolar diathermy to control the bleeding. Facial nerve recovery was achieved to Grade I (HB) classification in five cases and Grade II in two cases, Grade III in two cases and Grade IV in one case. Two cases defaulted the follow up. **Conclusions:** Identification of antrum and facial nerve landmarks are compulsory in any mastoidectomy. Cotton soaked with adrenalin is used to control of bleeding in the middle ear instead of diathermy. Early referral for facial nerve decompression gave better outcome of facial nerve recovery.