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LETTER TO THE EDITOR

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Intraorbital Wooden Foreign Body With Spontaneous Extrusion

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Dear Editor,

Orbital injuries with intraorbital foreign bodies (IOFBs) occur with a frequency of one in six (1). Children have a higher incidence of non-metallic IOFBs and a higher risk of developing endophthalmitis (2). Since intraorbital wooden foreign bodies (IOWFBs) are radiolucent, there may be difficulties in diagnosis by computed tomography (CT) or magnetic resonance imaging (MRI) (3). We presented a case missed IOWFB, which spontaneously extruded after two months.

A 15-years-old boy presented with swelling in left eyelids and crusted wound on the left medial canthus. His mother told that he fell down onto bushes 12 days ago. Visual acuities were 20/20 OD, no light perception OS. There was a wound on medial cantus left upper eyelid. He had proptosis and left upper eyelid edema. Extraocular movements of the left eye were severely restricted in all gazes and no light reaction. Anterior chamber did not reveal any inflammation. On funduscopic examination, there was optic disc edema. Skull radiography did not reveal sign of fracture and there were no abnormal finding. In orbital CT, there was a suspicion of foreign body in the medial of orbit.

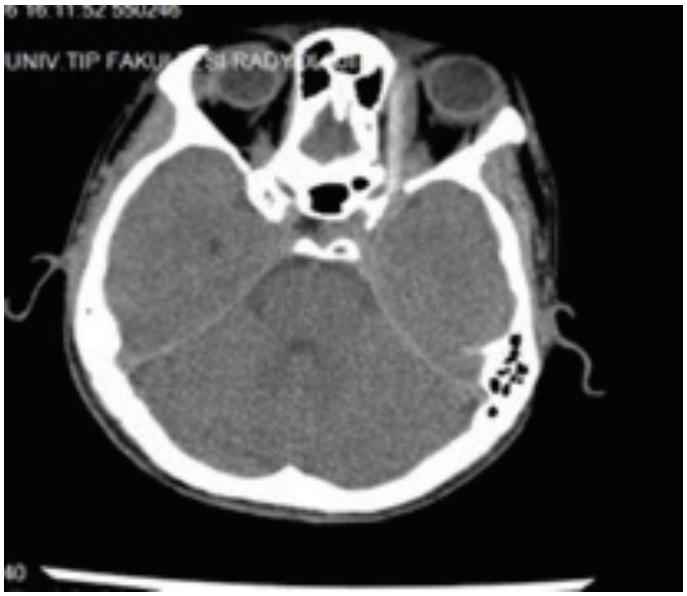

Figure 1. Axial CT scan, brain window.

The patient underwent exploration of the left orbit under general anaesthesia. Intraorbital foreign body was not found. Pus was drained and the wound closed with a drain.

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Figure 2 A. Early postoperative photography. There was upper eyelid edema and a crusted wound on the left medial canthus.

Figure 2 B. One month after spontaneous extrusion.

The patient was transferred to pediatric infectious diseases. After 2 weeks of systemic antibiotherapy, the patient was discharged. The patient did not attend postoperative visits and was called again after one month. He said that approximately 5 cm of wooden foreign body was spontaneously extruded from medial canthus.

Intraorbital wooden foreign body may cause severe complications such as foreign body retention, arterial aneurisym, orbital cellulites and may also cause unilateral optic atrophy through direct trauma and compression on optic nerve. The shape of the orbit is similar to a horizontal pyramid. For this reason, foreign bodies penetrating the orbit are directed to the apex and pass through the superior orbital fissure and optic canal. (4). The porous structure of wood and its characteristics of organic matter support bacterial ingrowth (5). Even if ocular trauma had been occurred long time ago, post traumatic changes in eye reveal itself as a recurrent inflammatory process or a silent hard mass (6). Intraorbital wooden foreign bodies may cause calcification and inflammatory granuloma. If IOWFBs break in the orbit during injury, this can lead to incomplete extraction or misdiagnosis (7).

In conclusion IOWFBs are not easily identifiable on CT. This case may cause misdiagnosis or missed diagnosis. Clinicians should be careful possibility of IOWFB presenting with periorbital travma.

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