An Unusual Case of a Cheek Abscess in a Patient with Oral Submucous Fibrosis

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ABSTRACT
Abscess formation in the soft tissues of the face is not an uncommonly encountered phenomenon in dental practice. However, the presence of oral mucosal pathologies can alter the manifestation of abscess formation. We report the illustration of a 51-year-old man, a known case of oral submucous fibrosis, who presented to us with a buccal abscess. After drainage of the abscess 2 days later, a piece of meat-bone was retrieved and found to be the causative factor. The paper discusses briefly the effects of such foreign body impaction and the clinician’s role in the management.

Keywords: Oral submucous fibrosis, Cheek abscess, Foreign body.

INTRODUCTION
The presence of foreign bodies lodged in the maxillofacial tissue is a relatively common situation. Foreign bodies can penetrate soft tissues through open wounds and lacerations sustained during trauma or via direct impact against them. However, impaction of a foreign body within the buccal mucosa of oral submucous fibrosis (OSMF) patient with a resultant cheek abscess is a rare and unreported clinical situation. The purpose of this report is to highlight the significance of a thorough history taking, clinical examination and keeping a high index of clinical suspicion for a probable foreign body impaction when dealing with unusual abscesses in the orofacial region.

CASE REPORT
A 51-year-old man presented with left-sided cheek pain of 5 days duration. He reported spontaneous occurrence of pain, followed by the appearance of a swelling in the left cheek. The pain was throbbing in nature, severe, localized, continuous and caused severe distress on chewing from the left side. The patient had a vague recollection of having developed pain and swelling in the left cheek after having his food 5 days back. His past dental history revealed that he had been diagnosed with oral submucous fibrosis about 15 months prior to presentation and was treated with intramucosal injections of corticosteroids and hyaluronidase. He had discontinued his arecanut chewing habit. Patient also gave history of endodontic treatment in the adjacent upper second molar 4 years prior.

Extraoral examination revealed no significant swelling over the left side of the face. The mouth opening was reduced with a 2.2 cm interincisal distance owing to oral submucous fibrosis. The entire oral mucosa was blanched. In the left buccal mucosa corresponding to the molar region there was a swelling approximately 0.5 cm in diameter. On palpation, the swelling was soft, fluctuant, severely tender (the patient barely permitted palpation) and approximately 1 ml of yellowish purulent exudate was expressed from the sinus opening on application of mild pressure. Vertical fibrotic bands were felt bilaterally in the posterior buccal mucosa and circumoral fibrotic bands were palpable in the upper and lower labial mucosa. Hard tissue examination revealed a clinically absent left maxillary first molar and a fractured silver amalgam restoration in the left maxillary second molar that had a sharp buccal margin. Blood investigation reports did not reveal any abnormal finding other than mild leukocytosis. Vitality testing and periapical radiographs for the adjacent teeth ruled out any odontogenic cause for the abscess. The patient was empirically prescribed oral antibiotic, amoxicillin, 500 mg TID for 5 days.

The patient reported back 2 days later with a yellowish, curved, hard mass, measuring about 5 × 2 mm. He stated that after 2 days of antibiotic therapy, the pain had reduced and he had been able to manipulate the soft tissues of the cheek, resulting in the mass coming out from the intraoral sinus opening (Fig. 1). In view of this development, a radiograph of the left cheek was obtained using an IOPA film to rule out any more such foreign bodies or its remnants but no remnants were evident in the radiograph. An in vitro radiograph of the calcified exfoliated mass revealed variable radiodensity that did not exhibit any feature of dental tissues (Fig. 2). This mass, was sent for decalcification; however, during processing the mass...
definitively proved, always poses a dilemma to the clinician, whether to leave it within and wait-and-watch, if the substance is deemed to be nonoffensive to the tissues or attempt its surgical removal. Although, it is not uncommon for foreign bodies to be impacted in the oral soft tissues, the inert nature of the impacted foreign body in most of the cases leads to absence of symptoms or the object may induce an intense inflammatory reaction in the surrounding tissues, that may get secondarily infected leading to abscess and sinus formation.  

This patient had already manifested OSMF in the past, thereby leading to loss of normal suppleness and elasticity, with stiffening of the mucosa. This could have enhanced the possibility of penetration of foreign body into the buccal mucosa further leading to abscess formation. The presence of impacted matter was not initially suspected after clinical examination given the absence of a specific history of tooth loss or trauma/blow. Radiological investigations were also not sought for the soft tissue as there was no suspicion of any solid body impaction initially. The extreme tenderness in the buccal region also precluded sufficient palpation of the swelling thereby adding to the lack of consideration of the diagnosis. It is indeed fortunate on our part to have retrieved the foreign body 2 days later. This can be attributed to the resolution of the abscess after the antimicrobial therapy and thus permitting the source of infection, the impacted mass in this case, to be exfoliated.

Thus, through this report, we attempt to alert other clinicians to consider the importance of the history and significance of radiographic investigation of the soft tissues as well. Because unlike the usual odontogenic etiology of a soft tissue abscess, an impacted foreign body can also be a cause and needs to be considered in the differential diagnosis especially in patients with mucosal pathology like OSMF.

REFERENCES