Opinion Article

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A Brief Note on Facial Trauma and Cardiovascular Surgery

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Description

Any physical harm to the face, also known as maxillofacial trauma, is referred to as facial trauma. Facial trauma can include soft tissue injuries like burns, lacerations, and bruises, as well as facial bone fractures such nasal fractures and jaw fractures, as well as damage to the eyes. Fractures, for example, may cause discomfort, swelling, loss of function, or changes in the contour of face tissues, depending on the type of damage. Facial injuries can result in disfigurement and loss of function; for example, blindness or difficulties moving the jaw are both possible outcomes. Although it is rarely life-threatening, face trauma can be fatal because it can cause serious bleeding or interfere with the airway; hence, ensuring that the airway is open and not threatened so that the patient can breathe is a top priority in therapy. Facial bone fractures, like all fractures, can cause discomfort, bruising, and swelling in the surrounding tissues. Nosebleeds can be caused by fractures of the nose, base of the skull, or maxilla. Nasal fractures can cause deformities in the nose as well as edoema and bruising. Deformities in the face, such as a depressed cheekbone or misaligned teeth, indicate the existence of fractures. Asymmetry may indicate face fractures or nerve injury.

Sports Injuries and Automobile Accidents

Falls, assaults, sports injuries, and automobile accidents are all common sources of face trauma in both children and adults. Face injuries are frequently caused by blunt assaults, such as punches from fists or objects. Wartime traumas such as bullets and bombs can also cause facial damage. Other reasons include animal assaults and work-related injuries such as industrial accidents. One of the most common causes of facial injuries is vehicular trauma. When the face collides with an element of the vehicle's interior, such as the steering wheel, trauma is prevalent. Airbags can also cause corneal abrasions and facial lacerations (cuts) when they deploy.

To rule out face fractures, radiography, or X-ray imaging of tissues, is utilised. Angiography can be utilised to figure out where the bleeding is coming from. Plain radiographs can be difficult to interpret due to the complex bones and tissues of the face; CT scanning is better for detecting fractures and analyzing soft tissues, and is frequently required to assess whether surgery is necessary, but it is more expensive and difficult to obtain. CT scanning is generally thought to be more conclusive and effective than X-ray in detecting face injuries. CT scanning is more likely to be utilised in persons who have many injuries and need CT scans to rule out alternative possibilities. Seat belt rules and public education to raise knowledge about the necessity of seat belts and motorcycle helmets are two ways to decrease face damage. Other preventative measures include efforts to limit drunk driving; changes to laws and their enforcement, as well as changes in societal attitudes toward the practice, have been advocated. Biomechanics research can be used to help designers create cars that are less likely to cause facial injuries. While seat belts help to lessen the quantity and severity of facial injuries in car accidents, airbags alone aren't very helpful at avoiding them. Safety measures, such as helmets, have been shown to minimize the risk of severe facial damage in sports.

Impede Ortracheal or Nasotracheal Intubation

Because airway compromise can proceed quickly and insidiously, and is potentially fatal, it is critical to ensure that the airway is open and not threatened throughout treatment. Material in the mouth that is obstructing the airway can be manually removed or suctioned out, and supplemental oxygen can be administered. Shifting the bones back into place in facial fractures that threaten to obstruct the airway lowers bleeding while also moving the bone out of the way of the airway.

Because of the swelling, tracheal intubation may be difficult or impossible. Nasal intubation, which involves placing an endotracheal tube through the nose, may be contraindicated in the presence of facial trauma because the tube could be driven through an undiagnosed fracture at the base of the skull and into the brain. A surgical airway can be implanted if facial injuries impede orotracheal or nasotracheal intubation. Because of the risk of complications and the difficulty of the procedures, cricothyrotomy and tracheostomy are only performed as a last resort when other treatments fail to secure an airway. Face trauma affects up to 50%–70% of those who survive car accidents. In most industrialized countries, other people's aggression has surpassed vehicle crashes as the leading cause of maxillofacial trauma; nonetheless, traffic accidents continue to be the leading cause in many underdeveloped countries. The increased usage of seat belts and airbags has been credited with

a decrease in the incidence of maxillofacial injuries; however these preventative measures have little effect on mandible fractures. Motorcycle helmet wearing reduces the risk of maxillofacial trauma by a factor of two. Seat belt and drunken driving regulations, tightly enforced speed limits, and the usage of airbags are thought to be contributing to a decrease in face bone fractures caused by automobile accidents. Facial fractures follow a fairly normal age distribution, with the highest frequency occurring between the ages of 20 and 40, and children under the age of 12 accounting for just 5%–10% of all facial fractures. Lacerations and soft tissue injuries are the most common types of facial trauma in youngsters. There are several reasons for the lower incidence of facial fractures in children: the face is smaller in relation to the rest of the head, children are less likely to be in some situations associated with facial fractures, such as occupational and motor vehicle hazards, children's faces have a lower proportion of cortical bone to cancellous bone, poorly developed sinuses strengthen the bones, and fat pads protect the facial bones.

Head and brain injuries are frequently related with facial trauma, particularly that of the upper face; 15%–48% of persons with maxillofacial trauma suffer from a brain damage. Coexisting injuries can influence how facial damage is treated; for example, they may be life-threatening and require care before face injuries. Cervical spine injuries (neck spinal injuries) are more common in those who have been injured above the level of the collar bones, and additional measures must be taken to avoid movement of the spine, which could worsen the damage.