INTRODUCTION
Orbital fractures account for 40% of craniofacial injuries; of the four walls of the orbit, the floor, which is extremely thin, is the most frequently injured. According to the pertinent literature, such fractures represent 67 to 84% of cases of orbital fractures. Orbital floor fractures can be broadly classified as pure or impure blowout fractures; the first are isolated orbital floor fractures, and the second are also associated with an orbital rim fracture, involving other skeletal elements: zygomatic, frontal, nasoethmoidal, or maxillary bones. A blowout fracture mechanism is not very clear; experimental and clinical studies have generally proposed two main theories: the hydraulic and the buckling mechanisms. Conventional approaches to the infraorbital rim/orbital floor have been cutaneous infraciliary incisions namely the subciliary, mid lower eyelid or subtarsal and infraorbital incisions. These approaches leave behind a scar which may be cosmetically disfiguring at times. A blowout fracture mechanism is not very clear; experimental and clinical studies have generally proposed two main theories: the hydraulic and the buckling mechanisms. Conventional approaches to the infraorbital rim/orbital floor have been cutaneous infraciliary incisions namely the subciliary, mid lower eyelid or subtarsal and infraorbital incisions. These approaches leave behind a scar which may be cosmetically disfiguring at times. The lower eyelid skin-muscle flap is now widely used for cosmetic blepharoplasty, primarily because of the ease and speed of dissection it offers. We present a case of 21 year old male patient with inferior orbital rim fracture which was managed with open reduction and internal fixation via subciliary approach.

CASE REPORT
A 21 year old male patient reported to the department of oral and maxillofacial of institute of dental surgery with the chief complaint of pain and swelling on right side of the face. As told by the patient he had encountered road traffic accident 2 days prior from the day of reporting. On clinical and radiographical examination he was diagnosed with right inferior orbital rim fracture. Open reduction and internal fixation was planned for the management of the fracture. The procedure was planned under general anaesthesia.

A subciliary skin incision was made 2 mm below and parallel to the lid-margin, beginning near the punctum and extending 5-8 mm past the lateral canthus in a skin crease(fig. 1). The dissection was carried directly down to the tarsal plate, separating the preseptal orbicularis oculi fibers from it. Both this and subsequent portions of the dissection are easier if the appropriate surgical planes are first located laterally, with dissection then proceeding medially by simple blunt scissors dissection. Once the tarsal plate was cleared of orbicularis fibers, the orbital septum, held tense by upward traction on the previously placed lid-margin sutures, was likewise separated from the preseptal orbicularis by spreading the two layers with scissors. The dissection followed the orbital septum down to the inferior orbital rim. A 5-8 mm incision through the orbicularis fibers underlying the lateral extension of the skin incision permitted the skin-muscle flap to be retracted away from the fractured site easily, without danger of...
tearing the fragile lid-skin. Standard subperiosteal exposure of the fractured site was then performed (fig. 2). After the exposure of the fracture reduction of the fracture was done and fixed with 1.5 mm 2 hole with gap stainless steel plate (fig. 3). After fracture repair, a 5-0 absorbable vicryl suture reapproximated the orbicularis muscle; the skin was sutured with 5-0 prolene. No frost suture was used to suspend lower eye lid post operatively. No marked edema was noticed post operatively and the wound healing was uneventful with very less to no scar formation (fig. 4).

DISCUSSION

The orbit protects the visual apparatus through the bone structures, and it acts as a receptacle. Nevertheless, the slightest trauma can provide serious damage. This is why the integrity of the eye and associated tissues must be evaluated accurately and quickly to avoid irreversible damage. The repair of the orbital floor fractures is not without risks, which must be taken into consideration when surgery is decided as a treatment of choice.²⁻⁹

A significant facial asymmetry, imaging evidence of the fracture, the age of the patient, and clinical signs and symptoms are extremely important in determining the surgical indications. In most patients, time allows for disappearance of initial edema and hemorrhage that in some cases are the causes of diplopia and enophthalmos. Fractures of the orbit that do not have functional or aesthetic injuries do not need surgical treatment.⁶

In our opinion, the indications for surgery are increased orbital pressure, persisting diplopia, enophthalmos, visual impairment, and hypoanesthesia of the infraorbital nerve. Management of orbital fractures is controversial because of the difficulty in evaluating the anatomy of the defect area, and amount of soft tissue herniation.⁸

Selection of a suitable incision for orbital floor and medial wall fractures is one of the challenging problems in plastic surgery. Subciliary, subtarsal, and transconjunctival incisions have been employed to approach the orbital floor fractures. Each of these approaches has its advantages and disadvantages that may make it more or less appealing to use. The lower eyelid skin-muscle flap is now widely used for cosmetic blepharoplasty, primarily because of the ease and speed of dissection it offers.¹¹

In the presented case report subciliary approach was used to repair the inferior orbital rim. This approach was preferred as there was no need to expose the medial or the lateral orbital wall. Furthermore, the scar is not evident.

REFERENCES

2. Kim KS, Kim ES, Hwang JH. Combined transcutaneous transethmoidal/transorbital approach


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LIST OF PHOTOGRAPHS

Fig 1: Showing Incision

Fig 2: Showing Exposed Fracture Site

Fig 3: Showing Reduced And Fixed Fracture Site

Fig 4: Showing Post Operative Scar)