

Tuberculosis of the oral cavity is often a consequence of active pulmonary tuberculosis. Tuberculosis of the oral cavity may occasionally result from a hematogenous spread of mycobacteria [1]. However, in the described patient, tuberculosis was not detected at any other body site.

Although the larynx is commonly involved in upper respiratory tract tuberculosis, the anterior pillar of the fauces and the adjoining soft palate are the most common sites of oral tuberculosis [4]. Deposits usually take place in the form of discrete nodules with yellowish apple jelly-like centers. These nodules may ulcerate leaving radiating scars, which are reasonably characteristic. However, no such gross pathology was observed in our case.

The soft palate is a dynamic muscular structure that effectively separates the oral and nasal cavities. Soft palate defects may cause hypernasal speech and food reflux into the nose upon swallowing. Thus, a functional mucomuscular soft palate structure and the removal of oronasal obstruction are the goals of palate reconstruction. In our case, the oronasal fistula was reconstructed using a posterior pharyngeal flap, and after surgery, the patient's hypernasality scores improved. Furthermore, no complication was encountered, and neither the tuberculosis nor the oronasal fistula recurred.

In conclusion, we used a posterior pharyngeal flap to reconstruct a rare soft palate defect that occurred after the tuberculosis of the soft palate, and achieved excellent functional outcomes.

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Clinical Experience of Morel-Lavallee Syndrome

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Morel-Lavallee syndrome is closed internal degloving of subcutaneous tissue from the underlying fascia by trauma. It was first described in 1848 by French physician Victor Auguste Francosis Morel-Lavallee [1]. The cavity developed and filled with fluid such as hematoma or liquefied fat etc. It was associated with significant soft tissue injury and frequently occurred on the greater trochanter [2]. Although not common, it can be very severe with infection.

The first case was a 70-year-old man who had

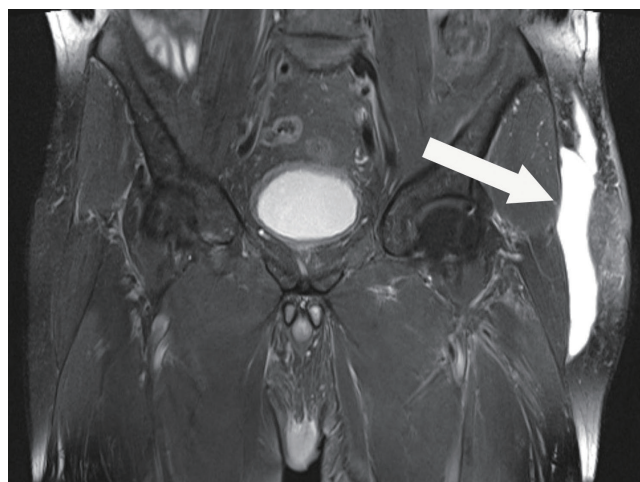


Fig. 1. Magnetic resonance imaging. Fluid collection (white arrow) was observed on left thighs.

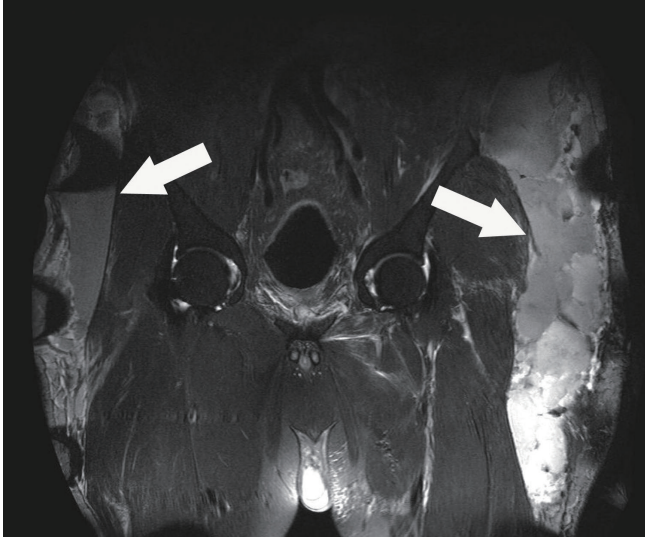


Fig. 2.
Magnetic resonance imaging. Fluid collection (white arrows) was observed on both thighs.

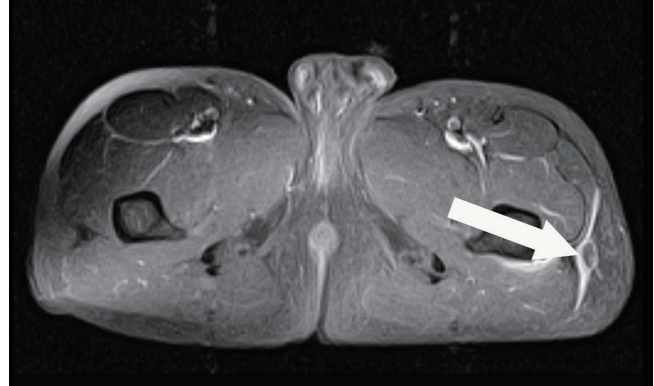


Fig. 4.
Femoral bursitis (with arrow). He was treated for Morel-Lavallee syndrome with percutaneous drainage with compression. He underwent one more operation for removal of the bursitis.

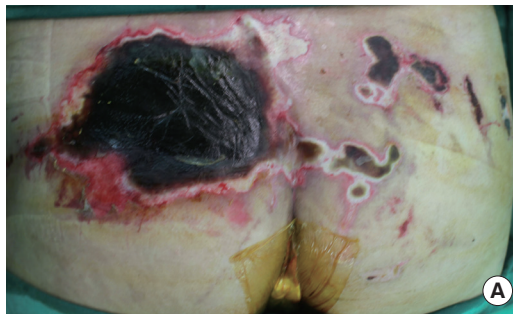


Fig. 3.
(A) Skin necrosis after injury. Demarcated large area of necrotic tissue was observed.
(B) Local flap and split thickness skin graft. Mild contracture was observed.

suffered a cultivator accident. Approximately two weeks later, swelling was observed on the left lateral thigh with fluctuation. Ultrasonography and magnetic resonance imaging (MRI) (Fig. 1) were performed and fluid collection was found. It subsided with debridement and percutaneous tube drainage (PCD) and compressive dressing. The patient was treated about 45 days. The second case was a 53-year-old man who suffered a pedestrian traffic accident. MR imaging showed a pelvic bone fracture and a huge hematoma on both thighs. (Fig. 2) He was transferred to plastic surgery 4 days later from the accident.

Pseudomonas aeruginosa infection was present on the necrotic tissue and necrosis spread like wildfire throughout the cavity. Massive debridement was performed and skin and soft tissue defects were observed on his lower back, sacral area, both buttocks, and lateral thighs. Surgical dressing was done daily and IV antibiotics were administered. The infection subsided and the defect was covered by split thickness skin graft and a local flap (Fig. 3). He was treated about seven months from the day of the accident. The third case was a 45-year-old man who suffered a fall from a ladder, with fluid collection on both thighs. PCD was attempted on both thighs and the symptoms subsided. However, femoral bursitis remained and was removed by simple excision (Fig. 4).

First and third cases subsided with percutaneous tube drainage and compressive dressing. But the second case, hard to relieve the infection. In this case, Morel-Lavallee syndrome was detected after infection was spread.

We report on three cases of Morel-Lavallee syndrome after severe soft tissue injury. Morel-Lavallee syndrome is uncommon and diagnosis is often delayed. MR imaging is good for assessment of Morel-Lavallee syndrome [3]. Various treatment protocols could be used, such as compressive therapy, sclerosant injection, pulse lavage, and open debridement [4,5]. It could be confused with recalcitrant bursitis of the knee, soft tissue tumors and lymphocele. Analysis of the protein contents and of the cytology of the liquid is the clue for differential diagnosis with them. We consider that the collected fluid and the cavity increased the severity. Infection is spread through the subcutaneous tissue on the internal cavity, and fluid could be a source of bacterial

growth. Therefore, drainage of fluid and removal of the cavity was needed before the infection occurred. For that reason, early detection is important, and knowledge of Morel-Lavallee syndrome and a high index of suspicion are needed.

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Extravasation of a Percutaneous Femoral Hepatic Infusion Device

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Using a femoral approach for inserting an intra-arterial percutaneous catheter-port device has recently been introduced for targeted treatment of hepatic tumors



Fig. 1.

The lesion upon consultation. There is dry eschar, edema, and skin color change in the right thigh of the patient.

[1]. Unlike permanent devices that have to be implanted surgically under general anesthesia, percutaneous catheter-ports may be installed under local anesthesia, a benefit for the many cancer patients who have already undergone cancer surgery. The subclavian route is also an option; however, there exists a risk of pneumothorax, reported to be around 4%, and also other complications such as local hematoma and brain infarction [2,3]. Thus, many institutions have been compiling their experience with femoral access and have reported relatively low complication rates [1,2].

Unfortunately, as with any injection device, there is always the possibility of extravasation, the leakage of injection material into tissue other than that targeted. Chemotherapeutic agents are generally cytotoxic and may cause necrosis of the surrounding tissue in the thigh and groin area; therefore, this medical emergency must never be underestimated.

A 29-year-old male patient was referred to the plastic surgery department for infection signs in his right inguinal area (Fig. 1). A hepatitis B carrier through vertical transmission, he had been diagnosed with hepatocellular carcinoma one month previously, and had received his first cycle of chemotherapy by way of a percutaneous intra-arterial catheter port device via his femoral artery.

While being started on his second cycle, he reported pain in the port area, and administration of epirubicin was immediately stopped. An estimated 15 mL of epirubicin had been administered. The port function was tested, and was found to be normal. Inflammation signs increased, and the port device