"Seven Deadly Sins" in Facial Trauma - Number Five, Six and Seven. Some Common Causes of Concerns, Complaint and Catastrophe and How to (Hopefully) Avoid Them.

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Disclaimer *- This review is not an extensive evidenced based review of the literature. It is based on the past 20 years experience I have gained in assessing and managing facial injuries. Its principles have served me well (so far). Hopefully it will help those readers who see these injuries on an infrequent basis.*

5 Giving poor advice / not arranging appropriate follow up.

Not all patients require a specialist referral, or a specialist review. But if they are discharged they do need to be given appropriate advice, including what problems they should look out for and when it may be necessary for them to return. It is also important to remember that co-existing concussion, fatigue, alcohol and drugs (both analgesic and recreational) can impair anyone's ability to retain information. Telling a very drunk patient to attend a follow up appointment may therefore result in non attendance, if they are too inebriated to remember where and when. Written instructions should ideally supplement what they are told.

Not all facial fractures require surgery. The decision to operate is ultimately made jointly between the patient and the specialist, after careful assessment and weighing up the risks and benefits. However, on occasion patients attend expecting an operation, because they have been told by the referring doctor they will need one. They may then be somewhat affronted when they are told that in fact, they do not. This potentially undermines confidence in at least one of the clinicians and possibly their department or hospital. This can be a common cause for dissatisfaction. As a general rule, referring practitioners should always refer for an "opinion", not for an operation.

Whether surgery is required or not, all patients with fractures involving one of the sinuses, even if only suspected, (i.e. most fractures anywhere in the face above the top teeth) should be advised 'Dont blow your nose". The concern here is that forceful blowing will force air (and bacteria from the nose) through the fractures into the soft tissues. This can occasionally result in infection. Orbital cellulitis - a severe infection behind and around the eye, although rare, is potentially both life and sight threatening. How long patients should refrain from blowing their nose is unknown and probably depends on a number of factors. Advice may therefore vary, depending on local practice. 3 weeks is a commonly used time frame. The same principle applies to flying and scuba diving, due to the pressure changes that occur, but again, a strong evidence base for the time frame is lacking. Generally speaking, antibiotics are not routinely prescribed, but all patients should be advised appropriately. If they do blow their nose and swelling occurs they should be told to return for further assessment.

With lacerations, lack of follow up, no advice about suture removal and aftercare of the wound, and false assurances regarding scarring are also causes of dissatisfaction. From a pragmatic viewpoint, currently there is no such thing as an invisible scar. Hopefully, with appropriate aftercare (such as continued wound support, gentle massage and other measures) the scar will be satisfactory. But as discussed in a previous article there are factors outwith the control of the surgeon and patient which can result in poor scarring.

All damaged teeth carry a questionable prognosis and in children it's important to remember this includes the unerupted 'adult' teeth. A tooth does not need to be broken or knocked out (avulsed) to be severely damaged. Any injury severe enough to damage the blood supply at the tip of the root can result in the death of the tooth and subsequent discolouration. Therefore all dental injuries need to be followed up by the patient's dentist, at least once, who can then monitor and manage as necessary.

6 Consent issues

Obtaining appropriate informed consent can sometimes be a problem, as guidance is generalised and it is left to the discretion of the consenting clinician as to what should be discussed. Precisely what constitutes a 'common' or 'severe' complication can be a matter of personal opinion. Some serious complications are so rare that the clinician may be reluctant to discuss them, for fear of unnecessarily frightening the patient. For example, blindness, skull fractures and even cavernous sinus thrombosis (a very serious condition), have been reported to follow routine nasal surgery. Similarly, avascular necrosis of the upper jaw (which can result

in loss of the jaw or teeth) has also been reported following injuries (and routine surgery).

Such complications are as rare as the proverbial 'Hen's tooth', but nevertheless devastating for the patient - one would think. Yet interestingly, I have encountered patients where loss of sight in one eye has not been considered serious, on the basis that they have two! On the other hand, the loss of a tooth may be considered a major complication in other patients. Failure to restore the patient's appearances exactly back to the way they were before their injury is also difficult to predict. Although this is always the aim of surgery, it can never be guaranteed.

Consent is therefore a potential medicolegal minefield, which requires careful, full and often frank discussion with the patient and sometimes other interested parties. Just like crossing the road, we all have to accept the risk we could be hit by a car. All precautions are taken, but some risk always remains. Nobody dies from an isolated broken nose, but in theory they could if they have an operation to straighten it. Guidance on the consent process is now changing.

7 Giving out information to a third party.

The devastating consequences of divulging patient information to a third party, especially over the phone, have been reported in the press in recent times. As seen in the last few years, these can be disastrous. Unfortunately people can be very deceptive. You never really know who you are talking to and a healthy degree of scepticism may save embarrassment or complaints later. Whilst we may all want to help the police in their investigations, this cannot override patient confidentiality. Even acknowledging that a patient is / was seen, is technically a breach. Breaches in confidentiality can occur despite the best of intentions.

Potential traps include;
1 Police enquiries following assaults or accidents
2 Relatives wanting to 'speak privately'
3 Cold calls and unannounced visits from the police or press.
4 Patients 'GP' or 'family friend' calling - clinicians need to be satisfied they are talking to a bona fide person - people can be devious
5 Leaving messages on a family answer phone.
6 Care is also required when divulging the circumstances of how an injury occurred Anecdotally the circumstances resulting in the injury may be somewhat dubious.
7 Patients in custody

If possible clinicians should therefore ask the patient for their consent to speak to third parties, at the earliest opportunity. If it's an assault or road accident, the police and family may well be calling for information at some point.

Medico-legal issues that can arise

- These are mostly self evident, as described above. Some useful principles to apply are

- Assume nothing when talking to patients

- Maintain a healthy degree of scepticism when dealing with third parties

- Plan for the worse, but always hope for the best, when consenting and operating.