

agreement in recent publications that gabapentin, pregabalin, and phenytoin can be effective in some patients.^{2,5} Tricyclic antidepressants may occasionally be used alongside the anticonvulsants,⁵ but are rarely used on their own. After trying carbamazepine and oxcarbazepine initially, we successfully managed our patient with gabapentin 1800 mg daily, in divided doses.

A diagnosis of glossopharyngeal neuralgia should be considered for any patient who presents with unilateral paroxysmal pain in the head and neck. The availability of specific diagnostic criteria can aid in inclusion or elimination of this condition from a differential diagnosis. If the condition is refractory to initial medical management, other drug treatments or procedures may be offered to ensure that symptoms are brought under control.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patient's permission

Ethics approval was not required for this project. The patient's consent was obtained.

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Incidental finding of an accessory inferior alveolar nerve

Sir,

Accessory mental foramina that lead to accessory mandibular canals have been described with a prevalence of 1.35% in a population studied by Choi and Han,¹ and bifid mandibular canals have been reported in 0.08% - 65%.² We report a case of bilateral sagittal split osteotomy (BSSO), in which an accessory inferior alveolar nerve (IAN) was noted.

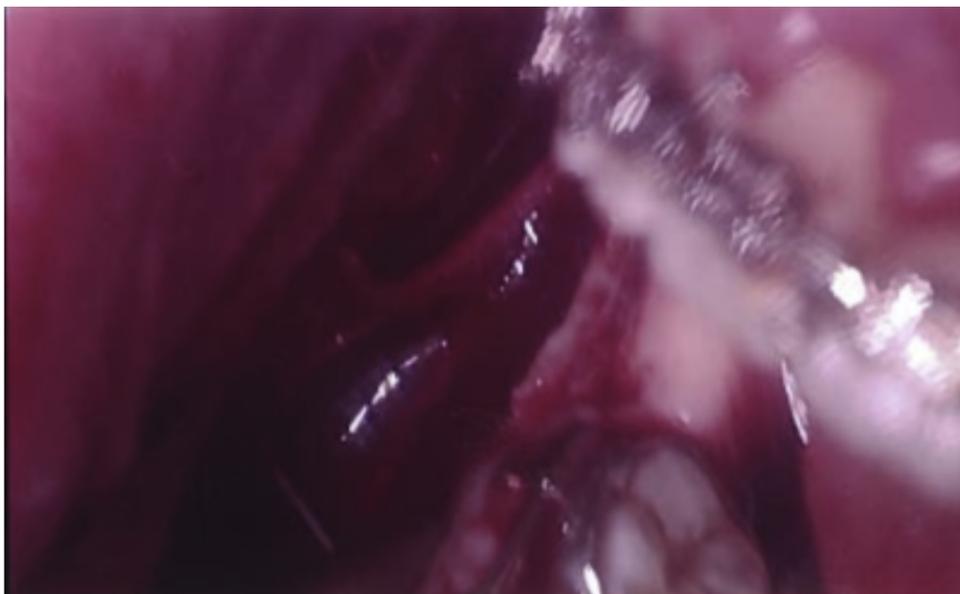


Fig. 1. Intraoperative photograph showing the accessory inferior alveolar nerve.

A 20-year-old, otherwise fit and healthy woman attended for a bimaxillary osteotomy. A sagittal split osteotomy was done using the Hunsuck modification, and was uneventful. At the time of splitting the right side an accessory IAN was noted travelling away from the main body of the nerve towards the buccal cortex, and then subdividing further (Fig. 1). There was no obvious accessory mental foramen, which suggested a bifid mandibular canal with a single mental foramen. This was not apparent from the preoperative plain radio graphs.

There is a wide variation in the prevalence of bifid mandibular canals found on plain radiography and cone-beam computed tomography. In a review of over 2000 orthopantomograms by Sanchis et al,³ 0.35% were identified as showing a bifid mandibular canal.

Histological examination shows that bifid mandibular canals contain nerve bundles and arteries.⁴ Possible complications could include: unsuspected bleeding, paraesthesia, traumatic neuroma, and nerve injury. We know that the position of the IAN can be highly variable, and its anatomical position has been postulated to have a potential impact on the likelihood of neurosensory disturbance after sagittal split osteotomy.⁵ This case highlights an uncommon anatomical variant of which the orthognathic surgeon should be mindful.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patient's permission

Ethics approval not required. All images are non-identifiable but the patient's written consent has been obtained and can be provided on request.

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Treatment outcomes of lateral canthotomy and cantholysis for orbital compartment syndrome

Sir,

Orbital compartment syndrome is a rise in intraorbital volume and pressure that reduces blood flow to the retina and optic nerve. It is characterised by decreased vision, proptosis, raised intraocular pressure, pain, and a fixed, dilated pupil, or a relative afferent defect of the pupil. Ischaemia rapidly leads to infarction and permanent visual loss. Immediate lateral canthotomy and cantholysis¹ is traditionally recommended within two-hours for optimal visual restoration.² We present the speed of treatment and visual outcomes of these patients in our hospital.

St George's Hospital audit department granted permission for this study (DB2070).

Patients who had been diagnosed with the syndrome and treated with lateral canthotomy and cantholysis between May 2011 and June 2016 were identified through the discharge codes “retrobulbar haemorrhage” or “lateral canthotomy/cantholysis”.

A total of 15 patients were identified (Table 1). Primary canthotomy and cantholysis did not adequately lower the orbital pressure in five. Of these one had successful repeat cantholysis, and four had an orbital drain inserted; one was operated on again 23 days later for a rebleed. It was not necessary to repair any lids.

The final Snellen visual acuity was 6/9 or equal to baseline vision before injury in 11/13 patients, and worse in 2/13, median (range) follow-up 217 (2–1708) days (Table 2).

This study highlights seven key learning points. Close ocular monitoring after lateral canthotomy and cantholysis is imperative to ensure that orbital pressure is adequately reduced,¹ as five patients required further urgent surgical treatment to achieve this.

Canthotomy and cantholysis beyond the traditional two-hour window can improve vision.

Four patients treated after 3.5, 8.75, 10, and 24 hours had documented visual improvement. Possibly an incomplete arterial occlusion extended the critical period beyond