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Case Report: Zygomatic-malar Abscess

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Abstract

We present a case of acute otitis media complicated by zygomatic-malar abscess in a 25-year-old patient with no previous medical/otorhinolaryngological history, who comes to consultation due to large left temporozygomatic swelling. Its atypical clinical presentation and the applied medical-surgical procedures are reported.

Keywords: Complicated otitis media; zygomatic abscess; temporozygomatic swelling; subperiosteal abscess

Clinical Case

25-year-old male patient, one-pack-per-week smoker, with no other relevant history. He seeks medical advice for a 1-week left otodynia, associated with scanty yellowish otorrhea in addition to a rapidly growing left temporozygomatic swelling. No antibiotic treatment.

Good condition on physical examination. Apyretic. Left ear: external auditory canal with mucopurulent secretions; dull, congestive tympanic membrane, without luminous shine and with punctiform attic perforation through which little purulent material comes out; no fetidness; no skin flakes. Myringosclerosis plaque (Fig. 3). Instrumental acoumetry with 256 Hz tuning fork; Weber lateralized to the left ear. Bilateral positive Rinne.

Diffuse left temporozygomatic swelling (Fig. 1-2) measuring approximately 8 x 4 cm (A-P) and (L). Its upper limit occupies the entire left supra-auricular region, reaching the tail of the eyebrow and ipsilateral malar region; modified root of the Helix, facial asymmetry and effacement of the retroauricular sulcus, displacement of auricular pavilion. Soft and depressible. Mastoid with mild erythema.

Tomography

Total occupation of mastoid cells on the left, bone erosion with soft tissue involvement. Collection at the level of temporal, zygomatic and left parietal bones. Septations. It measures 80 x 33 x 91 mm L, T and AP (Fig. 4-5). The laboratory study revealed a leukocytosis of 17,000 with neutrophilia (80%). Elevation of C-reactive protein 20 mg/dl, Hemoglobin 12.1 g/dl, Hematocrit 35.8%. Hospitalized patient with medical-surgical treatment. Puncture aspiration (Fig. 6) and surgical drainage. Ampicillin-Sulbactam 3 g every 6 hours, Ketoprofen 100 mg every 8 hours and Hydrocortisone 100 mg every

12 hours were administered. Due to the lack of an emergency block, mastoidectomy was not performed. The infectious process eroded the bone cortex of the temporal bone, dispersing pus between the cortex and the periosteum in the temporozygomatic region (Fig. 5). The causative germ was not isolated; empirical antibiotic therapy was sufficient. Chronic cholesteatomatous otitis media was ruled out; in its evolution, the eardrum was found to be normal with good shine and no collection in the tympanic box. Normal hearing. Control tomography with clear attic (Fig. 7).

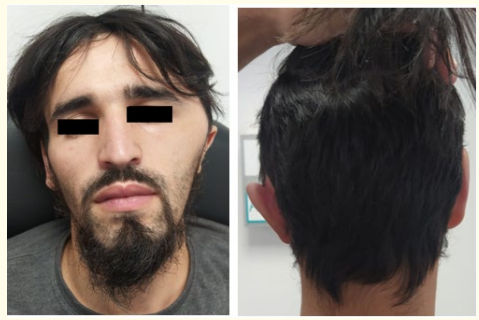

Figure 1-2: Left temporozygomatic swelling.

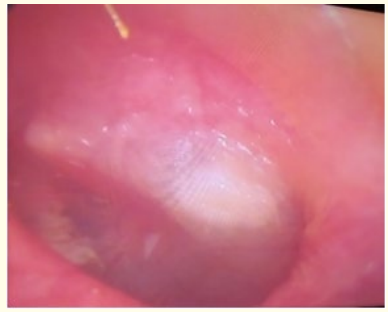

Figure 3: Left ear tympanic membrane.

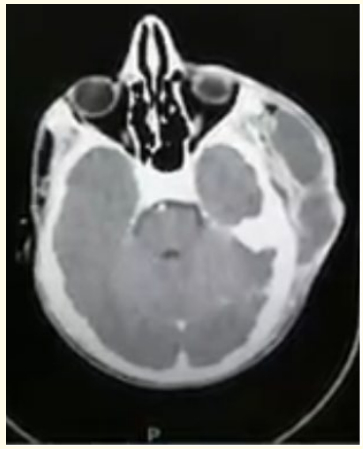

Figure 4: Temporozygomatic collection.

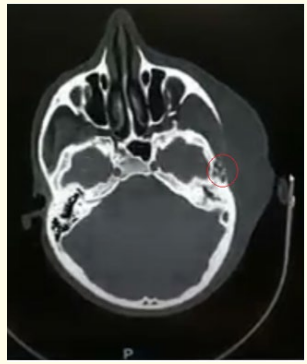

Figure 5: Externalization site.

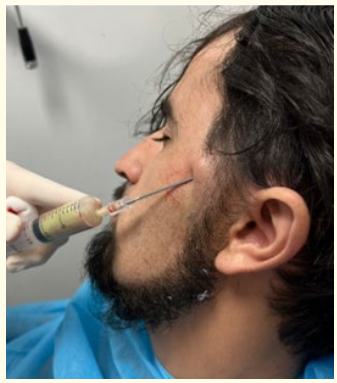

Figure 6: Puncture aspiration.

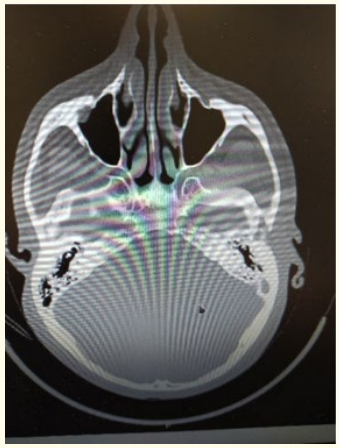

Figure 7: Clear attic, with no evidence of erosion in ossicular chain. No subperiosteal collection.

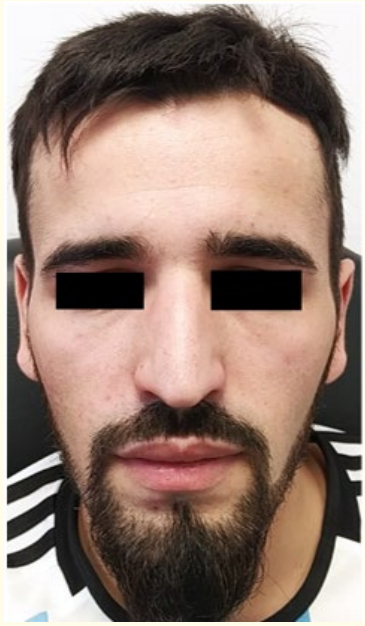

Figure 8: Symmetrical facies, 20 days later.