

# Fractures of the Supraorbital Rim: Principles and Management

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## SOMMAIRE

Il se peut qu'on demande aux dentistes d'offrir des consultations à des patients qui ont subi des traumatismes chroniques à leurs structures faciales. De ce fait, ils se doivent de reconnaître les fractures du bourrelet sus-orbitaire, même si elles se font rares, et de diriger le patient rapidement vers un spécialiste en chirurgie buccale et maxillofaciale ou un autre spécialiste s'y connaissant dans la prise en charge des fractures osseuses du visage. Les fractures du bourrelet sus-orbitaire coexistent souvent avec d'autres blessures cranio-maxillofaciales, notamment dans le cas des fractures de la face antérieure du sinus frontal. Dans le présent article, nous examinons la fréquence, la prise en charge et les complications associées au traitement des fractures du bourrelet sus-orbitaire chez les adultes.

Une série de 5 cas ont été examinés; 4 des 5 patients étaient des hommes, dont la moyenne d'âge s'élevait à 21,6 ans (allant de 17 à 28 ans). Toutes les blessures impliquaient le bourrelet sus-orbitaire et la face antérieure du sinus frontal, et elles coïncidaient avec d'autres blessures faciales. Le traitement allait de l'observation traditionnelle à la réduction ouverte et à la fixation interne des fractures. Aucune complication connexe périopératoire ou postopératoire ne s'est produite. Le suivi allait de 6 mois à 26 ans et, pour chaque cas, les résultats esthétiques étaient satisfaisants.

**Mots clés MeSH :** fractures, bone/diagnosis; fractures, bone/surgery; orbit/injuries

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Fractures of the supraorbital region are rare and are frequently associated with high-energy craniomaxillofacial trauma. When displacement of the orbital roof occurs, exploration and precise reconstruction are warranted to limit such ocular complications as exophthalmos, enophthalmos, proptosis, diplopia, restricted ocular movement, altered vision, pain and discomfort.<sup>1-13</sup> Fractures of the supraorbital rim can result in significant ophthalmologic and cosmetic morbidity (Fig. 1).

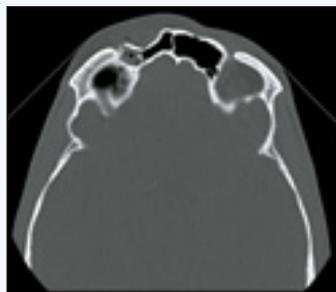
Isolated supraorbital rim fractures are rare.<sup>14,15</sup> However, an estimated 1% to 9% of facial fractures can involve the supraorbital rims

and the anterior table of the frontal sinus, and many supraorbital rim fractures are associated with other forms of craniomaxillofacial injury.<sup>1-6,13</sup> The degree of association has been reported to be 95% with fractures of the anterior table or wall of the frontal sinuses, 60% with the orbital rims, 60% with complex injuries of the naso-orbital-ethmoid region, 33% with other orbital wall fractures and 27% with Le Fort level fractures.<sup>1</sup> Many of these patients have multisystem injuries, most of which are neurologic.<sup>16,17</sup>

Adults who sustain such fractures are generally between 20 and 40 years of age, and the vast majority are male.<sup>1,2,18</sup> These fractures are



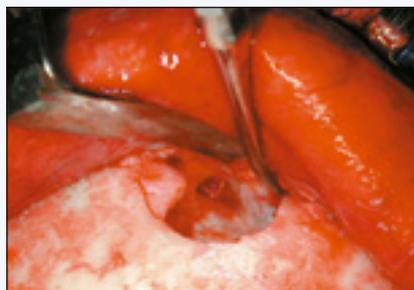
**Figure 1:** A 3-dimensional computed tomography (CT) image of patient with right supraorbital rim fracture.



**Figure 2a:** Axial CT image of patient with right supraorbital rim fracture and concomitant fracture of the anterior table of the frontal sinus.



**Figure 2b:** Sagittal CT image of patient with right supraorbital rim fracture and concomitant fracture of the anterior table of the frontal sinus.



**Figure 3:** Fractures of the supraorbital rim and anterior table of the frontal sinus exposed through a coronal incision.



**Figure 4:** Fractures of the right supraorbital rim and anterior table of the frontal sinus fixed with titanium mesh and 1.0-mm fixation screws.



**Figure 5:** Postoperative Water's view of fracture reduction.

associated with high-energy impacts, motor vehicle collisions being the most frequently reported etiology.<sup>1,18</sup> Many other causes have been identified, including tire explosions, ruptured garage door springs, chain saws, high-voltage electric shocks, swinging objects and falls from high places.<sup>1,3,9,10,18,19</sup> Statistical information is unavailable for the frequency of nondisplaced, or isolated, orbital roof fractures, although a few case reports appear in the literature.<sup>6,11,13</sup>

Patients with supraorbital rim fractures have characteristic physical signs and symptoms.<sup>1,2,12,18</sup> If they are seen soon after the traumatic episode, then a cosmetic deformity consisting of depression or flattening of the supraorbital ridge can be visualized. Later these injuries may present with intensely turgid periorbital ecchymoses, edema, soft tissue lacerations and paresthesia over the area of distribution of the supraorbital and supratrochlear nerves. If the fracture is displaced, enophthalmos, exophthalmos and proptosis may be noted, along with diplopia.<sup>12</sup> Ocular discomfort, epiphora, limitation of eye movement, increased scleral show and

increased width of the palpebral fissure have all been reported.<sup>12</sup>

A review of the literature reveals no uniform system for the classification of supraorbital rim fractures; most authors rely on descriptive terminology.

A nondisplaced supraorbital rim fracture generally requires no surgical intervention.<sup>20,21</sup> Treatment of concomitant neurologic or soft tissue injuries may be the only management needed. An orbital roof fracture, with undisplaced supraorbital rim involvement and no frontal sinus fracture, is common in children.<sup>22</sup> When the fractured segments are displaced, surgical exploration, reduction and stabilization are indicated. Supraorbital rim fractures frequently involve the frontal sinus. If the anterior table of the frontal sinus and the supraorbital rim are displaced, then operative treatment is required<sup>14,15</sup> (Figs. 2a and 2b).

A computed tomography (CT) scan can rule out damage to the posterior table of the frontal sinus. If there is a displaced fracture of the posterior table, then a dural tear is

**Table 1** Demographics and perioperative summary of a series of patients with frontal sinus and supraorbital rim fracture

Patient	Sex	Age (years)	Location of fractures	MOI	Associated injuries	Surgical approach	Hospital stay (days)	Follow-up
AD	F	18	Right SOR + AT	Bicycle fall	Multiple facial lacerations	ORIF via forehead laceration + frontal sinus drain	3	26 years
JK	M	22	Bilateral SOR + AT	Motorcycle accident	Open nasal fracture	ORIF via nasofrontal laceration + frontal sinus drain	3	25 years and 10 months
JL	M	23	Right SOR + AT	Baseball	Proptosis of right globe	ORIF via coronal flap	2	8 months
KF	M	28	Right SOR + AT	Skateboard fall	None	ORIF via coronal flap	2	6 months
LC	M	17	Right SOR + AT + PT	Bicycle fall	SD + right OF/IOR	None	2	6 months

AT/PT = anterior table/posterior table of frontal sinus; IOR = infraorbital rim; MOI = mechanism of injury; OF = orbital floor; ORIF = open reduction internal fixation; SD = subdural hematoma; SOR = supraorbital rim.

quite possible. However, treatment of such an injury is beyond the scope of this article and must be carried out with a neurosurgeon on the team. If the involvement of the fracture is limited to the anterior table of the frontal sinus, then an assessment of the frontonasal duct is important to assure continued drainage of the frontal sinus after fracture reduction. The patency of the frontonasal duct is important to help prevent the formation of a mucocoele of the frontal sinus, which could result in the formation of a mucopyocoele, a delayed but serious infectious complication.<sup>22,23</sup> These patients, therefore, require long-term follow-up. In patients who are at high risk of not returning for follow-up evaluation, cranialization of the frontal sinus with complete removal of all mucosal elements may be necessary to eliminate the risk of later mucocoele formation.<sup>10–13,24,25</sup>

The need for fixation in supraorbital rim fractures depends on the type of fracture encountered. The reduction is often stable once the fragments have been levered into position because of the absence of muscular displacing forces<sup>14</sup> (Fig. 3). Treatment involving the orbital skeleton has evolved considerably in the past century. Closed reduction, external fixators, antral packing and Kirschner wires were all used until open reduction with internal wire fixation was introduced in the 1940s and became widely adopted by the

1950s.<sup>24</sup> The introduction of rigid fixation into craniomaxillofacial fracture management revolutionized the treatment of orbital injuries<sup>25</sup> (Figs. 4 and 5).

### Patients and Methods

The records of patients treated by the members of the division of oral and maxillofacial surgery between January 1980 and December 2005 were reviewed retrospectively. Those with injuries not involving the orbit were excluded from this analysis.

### Results

A total of 5 patients — 4 males and 1 female — with supraorbital involvement are reviewed in this report (Table 1). The mean age at presentation was 21.6 years, with a range of 17–28 years. Two patients fell from bicycles, 1 from a skateboard, another from a motorcycle and 1 patient was struck in the orbit by a baseball. Most injuries involved the right side, although one patient had bilateral fractures. Approaching the supraorbital rim and frontal sinus by a coronal scalp flap, using an incision well above the hairline, or through a pre-existing facial laceration offered wide access with minimal surgical morbidity and satisfactory cosmetic results.

## Discussion

This series of patients supports previous observations that this fracture is more common in males than females.<sup>1,2,18</sup> The fractures in this series seemed to occur as a result of localized trauma and involved the anterior table of the frontal sinus in every case.

The treatment of supraorbital rim fractures is indicated for functional and esthetic reasons.<sup>14,15</sup> These fractures often require open reduction, as in the case of 4 of the 5 patients in this study. The results of treatment in all 5 patients in this series were satisfactory. No frontal sinus mucocoeles have occurred in these patients to date; however, long-term follow-up is necessary. ❖

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