

Case Report

Lingual and Sublingual Hematoma after Alcohol withdrawal Seizure Episode - A Case Report

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ABSTRACT:

Tongue swelling is a medical emergency in view of airway compromise. Rapid identification and proper management is utmost important for optimal patient outcomes. We describe here, how we managed the progressive lingual hematoma following alcohol withdrawal seizure episode.

Key words: Hematoma, alcohol withdrawal, seizure.

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INTRODUCTION:

Lingual hematoma mostly associated with either trauma or coagulopathy. A classification of acute enlargement of the tongue has been proposed by Renehen and Morton, based on various etiologies includes hemorrhage secondary to trauma, vascular anomaly, or disorder of coagulation, edema secondary to exudates or transudates, infarction, and infection.¹ Tongue is displaced in cephalad and posterior direction and thus results in airway compromise in cases of lingual/ sublingual hematoma.²

CASE REPORT:

A 47 year old male patient reported to the emergency department, jubilee mission hospital, Thrissur, kerala, with profuse bleeding from the oral cavity. On history

taking patient has 3 episodes of the GTCS on the same day. History of seizure episode one year back but not taking any medication. Attending relatives gave a history that he had stopped drinking from one week previously, following a daily alcohol intake habit of from past 20 years. The working diagnosis was alcohol withdrawal seizures complicated by lingual hematoma secondary to tongue biting. Known case of hypothyroidism and type 2 diabetes mellitus and on medication. On examination, profuse bleeding is there from the oral cavity, multiple blood clots are there. Bleeding is not controlling with pressure packs and by injection tranexa 1gm. Patient is complaining of difficulty in breathing. Tongue edema and sublingual hematoma is there. Swelling of the submental and submandibular regions is noted.

Investigations revealed thrombocytopenia (platelets 75,000 cells/cumm), and alcoholic liver disease (bilirubin 3.7 mg/dl, alkaline phosphatase 227 IU/l). Immediately thereafter, pt is shifted to OT and ENT was called for emergency tracheostomy and then patient is intubated. On examination, Large laceration of the tongue on lateral aspects on both sides and also on the ventral aspect below the tip of tongue is seen with active brisk bleeding, as well as obvious hematoma within the intrinsic tongue musculature (Fig 1). Suturing is done for the lacerated tongue and therefore bleeding is controlled to some extent, Mouth prop is placed to prevent recurrent tongue bite (Fig 2). Thereafter, he was transferred while intubated to the ICU, and he was connected to mechanical ventilation. He was kept on midazolam, fentanyl, and dexamethasone at 8mg intravenously for Q6h to relieve swelling, as well as antibiotics for 5 days. Furthermore, a removable biteblock was placed inside the oral cavity to prevent tongue biting, and wet gauze was applied to the exposed part of the tongue. Psychiatrist and neurologist were consulted, they followed the patient during his stay. Subsequently, the swelling decreased in size (Fig 3). On day 5, pt. was extubated successfully and transferred to the ward. The patient was observed in the ward for 1day and then discharged. The patient now has complete resolution of his symptoms.

Figure 1: Pre operative Clinical Picture showing hematoma



Figure 2: Intra operative Clinical Picture showing surgical closure



Figure 3: Post operative Clinical Picture showing complete healing



DISCUSSION

The various causes and treatment for the lingual hematoma have been discussed in literature. Though it is rare, it is associated with either trauma / coagulopathies. Common causes of traumatic lingual hematomas include: MVA's, assault, and seizures.³⁻⁵ Spontaneous lingual hematomas are usually a result of an inherited coagulopathy or treatment with anticoagulants (9,10). In this case, patient had lingual hematoma due to self inflicted trauma secondary to alcohol withdrawal seizures. Clinical signs of sublingual or lingual hematoma may include mass, swelling, bleeding, dyspnea, stridor, dysphagia and dysphonia. Because of its abundant vascularity, tongue enlargement can rapidly proceed to upper airway obstruction as it is displaced posterosuperiorly. As bleeding continues, the hemorrhage can spread into the sublingual space and eventually spread to the submandibular space. Immediate attention needed for securing the airway followed by hematoma evacuation and hemorrhage control. For establishing secured airway, Various methods are used i.e. active observation endotracheal intubation, blind nasal intubation, these two are not commonly used due to difficulty, fiberoptic laryngoscopy and finally surgical airway (cricothyrotomy or tracheostomy). In some case reports initially they have performed fiberoptic intubation, later they have done tracheostomy.⁶ In this case airway obstruction is identified as pt. complains of dyspnea and tongue is swollen and protruded out and oral cavity is full of blood clots. Immediately patient is shifted to OT ad tracheostomy performed and pt is intubated and sedated. Next prime concern is hemorrhage control, the management of such cases can vary depending on the cause of the hemorrhage. Those due to coagulopathies can be treated medically by reversing the coagulopathy and also by transfusing blood products. Whereas for traumatic etiologies, the management depends on the size of the hematoma and active bleeding. The treatment of traumatic hematomas can range from observation, local control, leech therapy, extraoral ligation of the offending vessel and embolization. Local control of hemorrhage

can include the use of direct local pressure, packing of the wound, suturing, and local surgical exploration and ligation or cautery of the appropriate vessels. When local control is not successful, invasive procedures should be carried out like angiography and embolization and extraoral ligation of the offending vessels which is done in some cases. In our patient, local control was successful by suturing of the lacerated wound.

To prevent recurrent biting of tongue we placed bite block. There have also been reports of avoiding more trauma to the enlarged tongue using various prosthetic appliances, such as a modified bite guard.⁷ This is the case report of the successful management of a patient with tracheostomy, corticosteroids, warm saline tongue compression, and the use of a bite block without the need for more invasive procedures like embolization and ligation. In conclusion, lingual hematomas requires rapid identification and early management. Because Upper airway obstruction is a common complication in these cases and requires appropriate management. Treatment of these hematomas can vary greatly depending on their etiology and extent.

CONCLUSION:

Tongue swelling is a medical emergency in view of airway compromise. Rapid identification and proper management is utmost important for optimal patient outcomes.

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