A total of 1,297 patients with maxillofacial and related traumas were treated in the Department of Otolaryngology, National Taiwan University Hospital from 1978 to 1982. There were 993 maxillofacial, 458 otologic, 120 intraoral and 43 laryngotracheal traumas respectively (many patients had more than one type of trauma). Over a half of the 478 facial bone fractures, the cause was due to motor vehicles especially motorcycles. The purpose of this presentation is to share with you our experience in handling some of these patients.

1. Comminuted nasal bone fracture

After primary suture of the soft tissues, the first revision surgery was performed 6 months later. We applied either septal cartilage or auricular cartilage for support especially at the supratip area. The results were very satisfactory.

2. Traumatic CSF rhinorrhea

Traumatic CSF rhinorrhea is usually stopped spontaneously. If it persists for more than 3 weeks, we advise the patient to undergo surgical intervention. Polytomography and/or CT scan can occasionally disclose the site of the leak. In suspicious anterior cranial fossa leak, we made coronary incision and osteoplastic technique, then searching the site of the leak under the microscope. We were very fortunate to find out the site of the leak in four patients. Then the bony defect was repaired with a soft tissue graft and glued with Histoacryl (B. Braun Melsungen AG, West Germany).

3. Blow-out fracture

Pure blow-out fracture of the orbit was not very often seen in our series; there were only 28 patients out of 478 facial bone fractures. Because of diplopia and positive traction test seven out of these 28 patients underwent surgical intervention. For the early cases (within 2 weeks from the trauma), the antral route is usually sufficient to set back the herniated orbital contents with the aid of traction sutures from the eye. If reconstruction of the orbital floor should become necessary, subperiosteal onlay grafting with autologous materials such as bone or cartilage taken from the antral wall, septum or auricle was performed through the infraorbital route. However on some occasions, thick silastic sheet was the alternative material.

4. Multiple facial bone fractures

For better patient service, there is a consensus in our institution. That is patients with mainly soft tissue trauma are handled by the plastic surgeon, those with occlusal problem by the oral surgeon, those with sinus or temporal bone injury by the otolaryngologist. Therefore a patient with multiple facial bone fractures is usually operated upon by two specialities in one operative setting.

5. Temporal bone fracture

We believe there are three types of temporal bone fractures, namely tympanic portion, longitudinal, and transverse. Fracture of the tympanic portion can be corrected immediately by using a long nasal speculum under local anesthesia in order to prevent the ear canal from later stenosis. Delayed type of traumatic facial nerve palsy is not a surgical candidate, because the outcome of conservative measures is quite good in our experience. In longitudinal fracture (preservation of inner ear function) with immediate type of facial palsy, surgical decompression as soon as possible is usually rewarding in terms of facial nerve function and hearing. While in transverse fracture (loss of inner ear function)
with facial palsy, the patient is usually in very grave condition, and is seldom referred to us in the early stage. Therefore we recommend the procedure of hypoglossal-facial cross-over to be done six months after the trauma, if the patient requests to have his paralyzed facial expression improved. Seven patients underwent the cross-over procedure with satisfactory results.

**Conclusion and Summary**

The treatment of maxillofacial trauma is often very promising. It should encourage the otolaryngologist to be more active in handling the patients. There is no need for competition among specialities. If the patient sustains trauma to the sinus and/or temporal bone, the otolaryngologist should play the keyrole in treating him.