ANGULAR VEIN THROMBOPHLEBITIS—REPORT OF A CASE

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Most cases of acute swelling of the cheek are due to dental infection. Antral infection rarely causes visible swelling in the absence of a breach of the anterior wall of the antrum due to: a congenital dehiscence; a previous Caldwell-Luc antrostomy; a carcinoma of the antrum, or a misplaced trocar and cannula in an attempted antral washout.

Other causes include superficial lesions such as insect bite, boil, and bruising; and osteomyelitis of the maxilla. The latter occurs "spontaneously", i.e. in the absence of other local pathology or trauma, only in sucklings.

The following case presented the problem of a sudden and, at first, not easily explained inflammatory swelling of the cheek.

J.J., a butcher, aged 57, was admitted to hospital with the following history:

Two days previously he had noticed pain on the left side of the bridge of the nose. When he woke the following day, his left eyelids were swollen, the lower more than the upper. He was given a single injection of penicillin. On the following day his pain was less, but the left cheek was swollen, particularly below the left eye.

On questioning, he felt well. He had not had a recent cold, and had no nasal symptoms since removal of polyps from both sides of his nose 8 years previously. Two days before the symptoms first started he had pulled some hairs out of his left nostril.

On examination, he was a fit looking man with a normal temperature. There was œdema of the left eyelids and conjunctiva. The left cheek was swollen with marked tenderness and reddening over the frontal process of the maxilla. There was no inflammation of the skin of the left nasal vestibule and the nasal cavities were normal on anterior and posterior rhinoscopy. No pus was visible.

On dental examination, the left upper premolars and molars were missing. The canine and incisors were loose but not carious. There was no swelling of the palate or in the gingivo-labial sulcus.

X-ray examinations, showed no retained roots or root abscesses in the left upper jaw and the sinuses were normal.

At this stage no obvious cause for the inflammatory swelling had been found. The history of trauma to the nasal vestibule had been elicited but in the absence of any local inflammation had been ignored.

Treatment

He was given a course of penicillin $\frac{1}{2}$ m. units 6 hourly and sulfamethazine $\frac{1}{2}$ gm. 6 hourly.

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Progress

Over the next 2 days the swelling subsided to reveal a tender elongated swelling at the site of the left angular vein. The tenderness became less and antibiotics were stopped after 5 days. He was discharged with a palpable cord-like thickening following the course of the vein. When seen in Out-Patients 2 weeks later, this had disappeared. A diagnosis of thrombophlebitis of the angular vein was now made.

This is certainly not a common condition. A search through the records of a group of hospitals seeing over 31,000 new patients a year revealed no diagnosed cases. It may well be more common, however, than is recognized. One patient has been seen with an undiagnosed inflammatory swelling in the region described above, following severe conjunctivitis. There was no record in the notes of a palpable angular vein and the diagnosis of thrombophlebitis of the angular vein appears not to have been considered.

It is suggested that thrombophlebitis of the angular vein should be considered in the differential diagnosis of acute inflammatory swellings of the cheek when the commoner causes have been excluded.

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