

differentiating benign from malignant, whereas a positive FNAB can also indicate histologic type, and therefore differentiate between small cell and non-small cell lung cancers. In addition, PET is generally only available in larger tertiary care centres.

### Recommendations

We believe that FNAB has no role in the management of the suspicious solitary lung mass in patients who are willing surgical candidates. In such cases, the outcome of the biopsy is irrelevant, as thoracotomy will be undertaken regardless, given the high false-negative rate. One concern is that the surgeon may be operating on patients with small cell lung cancer. In such cases, however, surgery plays an important role as part of a multidisciplinary approach to the disease.<sup>5</sup>

FNAB should be used for the following:

- patients who are medically unfit and could not tolerate surgery
- patients who refuse surgery
- patients with advanced disease (local or metastatic).

In these instances, FNAB may provide a diagnosis and thus allow institution of appropriate therapy. Biopsy of centrally located lesions less than 1 cm in diameter is unlikely to be successful and is associated with a higher complication rate.

### References

1. Calhoun P, Feldman PS, Armstrong P, Black WC, Pope TL, Minor GR, et al. The clinical outcome of needle aspirations of the lung when cancer is not diagnosed. *Ann Thorac Surg* 1986;41:592-6.
2. Chaffey MH. The role of percutaneous lung biopsy in the workup of a solitary pulmonary nodule. *West J Med* 1988; 148:176-81.
3. Colquhoun SD, Rosenthal DL, Mor-ton DL. Role of percutaneous fine-needle aspiration biopsy in suspected intrathoracic malignancy. *Ann Thorac Surg* 1991;51:390-3.
4. Dewan NA, Reeb SD, Gupta NC, Gobar LS, Scott WJ. PET-FDG imaging and transthoracic needle lung aspiration biopsy in evaluation of pulmonary lesions — a comparative risk-benefit analysis. *Chest* 1995;108:441-6.
5. Higgins GA, Shields TW, Keehn RJ. The solitary pulmonary nodule. Ten-year follow-up of veterans administration-armed forces cooperative study. *Arch Surg* 1975;110:570-5.
6. Lillington GA. Hazards of transthoracic needle biopsy of the lung. *Ann Thorac Surg* 1989;48:163-4.
7. Weisbrod GL. Transthoracic percutaneous lung biopsy. *Radiol Clin North Am* 1990;28:647-55.
8. Landreneau RJ, Hazelrigg SR, Ferson PF, Johnson JA, Nawarawong W, Boley TM, et al. Thoracoscopic resection of 85 pulmonary lesions. *Ann Thorac Surg* 1992;54:415-20.

## SESAP Critique / Critique SESAP

### ITEMS 629-632

Clinical signs and symptoms of mandibular fractures include facial asymmetry and swelling, trismus and limitation of mandibular movement, malocclusion, lengthening of the face, paresthesias of the lower lip and chin due to injury to the inferior alveolar nerve, and ecchymosis of the floor of the mouth.

Consistent clinical signs and symptoms of malar or zygomatic complex fractures (tripod fractures) include ecchymosis and edema and numbness of the anterior cheek due to injury to the infraorbital nerve. Depending on the degree of displacement, other possible signs and symptoms include flattening of the cheek, infraorbital rim step defect, and decreased extraocular muscle function. Unilateral malar fractures do not produce malocclusion or facial lengthening. Trismus or limitation of mandibular movement may be caused by pressure on the coronoid process of the mandible by the zygoma as well as by swelling in the temporal region.

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### References

- 629-632/1. Anton MA, Jacobs JS: Mandibular fractures, in Georgiade GS, Georgiade NG, Riefkohl R, Barwick WJ (eds): *Textbook of Plastic, Maxillofacial and Reconstructive Surgery*. Baltimore, Williams & Wilkins Co, 1992, pp 433-451
- 629-632/2. Manson PN: Management of midfacial fractures, in Georgiade GS, Georgiade NG, Riefkohl R, Barwick WJ (eds): *Textbook of Plastic, Maxillofacial and Reconstructive Surgery*. Baltimore, Williams & Wilkins Co, 1992, pp 409-432