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Proceedings of the 139th Semon Club, 21st May 2010, ENT Department, Guy's and St Thomas' NHS Foundation Trust, London, UK

Chairman: Miss Elfy B Chevretton, Guy's and St Thomas' NHS Foundation Trust
Secretary: Mr Sherif Haikel, Guy's and St Thomas' NHS Foundation Trust
Pathologists: Professor Leslie Michaels, and Dr Ann Sandison, University College London
Radiologist: Dr Steve Connor and Dr Ata Siddiqui, Guy's and St Thomas' NHS Foundation Trust
Professor Michaels awarded a prize for the best presentation of the meeting to Dr Richard Steven

Head and neck session

Chairman: Mr Ricard Simo

A benign left supraclavicular mass with malignant features

O Olaleye, B Fu, M Black
From the William Harvey Hospital, Ashford

Introduction

Spindle cell lipomas are benign, lipomatous tumours which typically occur on the posterior neck, shoulders or upper back of elderly men. They are composed of fat, spindle cells positive for cluster of differentiation 34 glycoprotein, and 'ropey' collagen on a myxoid matrix.

The presented case highlights a rare presentation of spindle cell lipoma, and emphasises the need for pre-operative diagnosis.

Case report

A 63-year-old man presented with a pre-existing left supraclavicular mass that had recently increased in size. Fine needle aspiration cytology and computed tomography were performed, and the results discussed in the multidisciplinary team meeting. Excisional biopsy was recommended.

Radiology

The computed tomography (CT) scan of the neck, with contrast, showed a left-sided, $46 \times 69 \times 91$ mm, supraclavicular mass of fat density, with fine internal septations. It lay posterior to the sternocleidomastoid muscle and superficial to the paravertebral muscles.

The lesion could not be classified as a simple lipoma due to its internal complexity. A low-grade liposarcoma could not be excluded. A CT scan of the chest was normal.

Histopathology

Fine needle aspiration cytology was indeterminate. The resected specimen showed mature adipocytes interspersed with fibrous septae containing bland spindle cells with no evidence of malignancy. Further immunohistochemical analysis showed spindle cell lipoma cells positive for cluster of differentiation 34 glycoprotein.

Management

Excision biopsy of the mass was performed. This was technically difficult, as the mass invaginated around the brachial plexus and extended posteriorly through the prevertebral fascia.

The patient recovered well post-operatively, with no neurological deficits.

Conclusion

Spindle cell lipomas are rare, benign tumours. Establishing a pre-operative diagnosis based on clinical context, imaging and immunohistochemistry is crucial for pre-operative surgical planning and subsequent management.

Ball-valving, transforming liposarcoma of the cervical oesophagus

D Black, D Sandooram, J Weighill
From Brighton and Sussex University Hospitals

Introduction

Oesophageal liposarcomas are very rare, and generally arise as de novo tumours. The risk of metastatic disease depends on the subtype. No consensus exists regarding the best management strategy.

Case report

A 62-year-old man presented in 1997 with choking episodes. Videofluoroscopy showed a 6 cm, intraluminal, pedunculated mass in the cervical oesophagus. A subsequent oesophagoscopy was normal, and the patient was discharged.

He re-presented in 2006 with similar symptoms. Nasendoscopy showed an 8 cm, smooth swelling filling the right pyriform fossa and encroaching upon the larynx.

Radiology

Computed tomography scanning confirmed a hypopharyngeal and submucosal swelling with the density of fat.

Management

Rigid endoscopy showed the lesion to be projecting upwards from the posterolateral wall of the cervical oesophagus. Large biopsies were taken, and the hypopharyngeal component was debulked with a laser.

Histology

Histological analysis indicated a well differentiated liposarcoma.

Subsequent management

The implications were discussed with the patient at the multidisciplinary clinic. Well differentiated liposarcomas carry a minimal risk of metastasis. As the patient was symptomatically better, it was decided to monitor him clinically and radiologically.

In August 2009, the patient reported increasing dysphagia. Further biopsies showed a de-differentiated liposarcoma. This has a 15–20 per cent risk of metastasis. The patient underwent a left lateral pharyngo-oesophagotomy for removal of a 10 cm tumour from the lumen and wall of the cervical oesophagus. At the time of writing, the patient was swallowing normally, and remained under follow up.

Discussion

Mr Simo emphasised the importance of discussing the possibility of transformation before advocating conservative management. Miss Chevretton commented that these lesions can be managed by snaring at an early stage.

The continuing search for the unknown primary

I Amir, S Penney, A Belloso

From the Royal Blackburn Hospital

Introduction

Branchial cyst carcinoma is thought to occur due to malignant degeneration of epithelial remnants within a branchial cyst. Differentiating it from a cervical lymph node metastasis from an unknown primary tumour remains a diagnostic controversy. The diagnostic criteria introduced by Khafif (1989) include the absence of an identifiable primary tumour with corroborating histological features.

Case report

A 62-year-old woman presented with a four-week history of a painless lump in level II on the left side of her neck. No other abnormality was found during clinical examination. Fine needle aspiration cytology of the lump revealed squamous cell carcinoma.

Radiological findings

Computed tomography scanning showed this to be a necrotic mass with no evidence of a primary tumour. Positron emission tomography also failed to identify a primary tumour.

Histological findings

Histological analysis confirmed the presence of a branchial cyst, with evidence of a variable degree of dysplasia progressing to invasive carcinoma. Biopsy of the tonsils and tongue base showed no evidence of malignancy.

Management

The patient underwent a left modified radical neck dissection. At the time of writing, despite the convincing histological diagnosis of primary branchial cyst carcinoma, we were still considering post-operative elective mucosal irradiation to high risk primary sites, as well as to the left neck.

Conclusion and lessons learned

Accurate diagnosis of primary branchial cyst carcinoma is challenging. We present a convincing case of branchial cyst carcinoma supported by exhaustive radiological evaluation and reliable histological features. Despite the diagnosis, we believed that this case should be managed as a neck node metastasis from an unknown primary.

Non acquired immune deficiency syndrome related Kaposi's sarcoma of the oropharynx

T Gutierrez, A Joshi, R Simo

From Guy's Hospital, London

Background

Kaposi's sarcoma is known as one of the illnesses which defines acquired immune deficiency syndrome (AIDS). Up to 38 per cent of patients with AIDS will develop Kaposi's sarcoma, and two-thirds of these will have involvement of the head and neck. It is important that physicians are familiar with the appearance and biological behaviour of Kaposi's sarcoma, and are aware that diagnosis and treatment of AIDS must commence at the earliest opportunity.

Case report

An 85-year-old black African woman presented with a three-month history of sore throat with associated left-sided otalgia. Examination revealed a mass in the left tongue base and fullness of the left tonsillar area. Panendoscopy and biopsy were performed.

Radiological findings

Computed tomography and magnetic resonance imaging revealed a left tonsillar tumour with no nodal disease (stage: tumour 2 node 0 metastasis 0).

Histological findings

The histological features indicated Kaposi's sarcoma. The tumour was positive for human papillomavirus type 8 antibodies, which confirmed the diagnosis.

Management

The patient tested negative for human immunodeficiency virus (HIV). She was treated with radical radiotherapy to the primary site and neck. Her recovery was uneventful, and at the time of writing she was receiving regular follow up.

Conclusion and lessons learned

We present a very rare case of non-AIDS-related Kaposi's sarcoma, in order to highlight the importance of not assuming that patients with this lesion are HIV-positive.

Discussion

Dr Sandison agreed with the histological diagnosis, and confirmed the association of non-AIDS Kaposi's sarcoma of the oropharynx with this age group. The panel agreed that the optimum management should be delivered by a multidisciplinary team. In addition, panel experiences with similar clinical cases were mentioned.

Unusual supraglottic mass causing airway obstruction

D Brian, A Joshi, R Simo

From Guy's Hospital, London

Introduction

We present an unusual cause of acute upper airway obstruction which required urgent tracheostomy.

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Case report

A 68-year-old man presented with four days of increasing breathlessness, dry cough and dysphonia. Worsening hypercapnia necessitated artificial ventilation. A swelling was seen obscuring the glottis. Microlaryngoscopy revealed supraglottic erythema and oedema extending to the glottis, with a smooth mass centred on the left aryepiglottic fold and prolapsing onto the left vocal fold.

Radiological findings

Computed tomography revealed a discrete, enhancing, 26 × 23 × 35 mm mass in the left supraglottic region, with hypervascularity and no lymphadenopathy. Angiography demonstrated abnormal vessels in the left pharyngo-epiglottic fold continuous with the mass, suggesting a haemangioma.

Histological findings

Biopsies taken on two occasions from multiple sites revealed keratosis with no evidence of dysplasia or malignancy. Histology of the final resection specimen was consistent with a paraganglioma.

Management

Surgical tracheostomy was performed without complication, but persistent airway obstruction prevented decannulation. Repeated microlaryngoscopy demonstrated no change in the lesion size. The patient opted for further surgery, and underwent successful resection of the suspected haemangioma via open laryngofissure.

Discussion and conclusion

Professor Michaels agreed with the histological diagnosis. Paragangliomas represent an uncommon cause of laryngeal mass and airway obstruction in adults. This case illustrates the challenges in diagnosing this unusual supraglottic neoplasm, and the utility of open laryngofissure in its surgical management.

Otology and skull base session

Chairman: Mr D Jiang

A case of submandibular swelling

G Yassin, N Gibbins, A D'Souza

From University Hospital Lewisham, London

Background

Watt Eagle first described the symptom of orofacial pain secondary to calcification of the stylohyoid ligament or an elongated styloid process, in 1937. Since then, the range of presenting complaints has widened; now, over 30 different symptoms have been documented.

Case report

A 58-year-old man presented with a right-sided, submandibular swelling of three weeks' duration. He complained of difficulty swallowing crisps and sticky sweets. There was no dysphonia or pain. Past medical history included type II diabetes mellitus, and there was a family history of oesophageal carcinoma. Examination confirmed a firm, non-tender, 1 × 2 cm mass in the right submandibular area. Whilst awaiting surgery, the patient suffered a transient ischaemic attack.

Radiological findings

Ultrasonography demonstrated a calcified mass thought to represent either a submandibular gland stone or calcification of the laryngeal cartilages. A computed tomography scan revealed ossification throughout the stylohyoid ligaments bilaterally. The mass was found to be related to the articulation between the calcified right stylohyoid ligament and the hyoid bone.

Management

Due to the risk of damaging adjacent structures during surgery, the patient was managed conservatively.

Conclusion

We present the first case of Eagle's syndrome presenting with a submandibular swelling due to a calcified stylohyoid ligament. We believe that this calcified ligament may have been an aetiological factor in the patient's transient ischaemic attack. Dr Connor recommended a magnetic resonance angiogram or dynamic ultrasound scan with head-turning, to assess whether the calcified stylohyoid ligament was impinging on the carotid artery.

A rare cause of acquired conductive hearing loss in an adult

F Sipaul, S Gillett, J Hamilton

From Gloucestershire Royal Hospital, Gloucester

Background

In adults, congenital cholesteatoma is rare, whereas otosclerosis is a common cause of acquired conductive hearing loss.

Case reports

We present two cases in which a diagnosis of otosclerosis was made based on clinical and audiometric findings. In both cases, the tympanic membrane appeared normal. Neither patient had a history of previous middle-ear surgery or ear infection. During middle-ear exploration, middle-ear cholesteatoma was found in both patients; surgery was abandoned and a computed tomography (CT) scan requested.

Radiological findings

Computed tomography scanning confirmed the presence of soft tissue medial to the intact tympanic membrane. Appearances were consistent with cholesteatoma.

Management

Subsequent mastoid surgery was performed on both patients.

Conclusion

Congenital cholesteatoma should be part of the differential diagnosis of conductive hearing loss even in adults with an apparently normal tympanic membrane. This raises the question of whether CT scanning of the temporal bones should be a routine part of the evaluation of such patients. Mr Aymat was of the opinion that CT scanning was not routinely indicated if the patient had a positive family history of otosclerosis. However, Mr A Fitzgerald O'Connor believed that such patients should routinely receive a scan, particularly if the hearing loss was unilateral. Mr D Jiang agreed that scanning was indicated, adding that CT scanning was also of use in assessing the state of the stapes and footplate pre-operatively, in cases of otosclerosis. Mr D MacMillan (Guildford) said he would scan patients with an unexplained conductive hearing loss in the absence of a family history of otosclerosis.

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Progressive unilateral hearing loss and dizziness with an erosive soft tissue mass in the temporal bone

A Hay, I Pai, M Gleeson
From Guy's Hospital, London

Introduction

We report a rare temporal bone tumour which presented a diagnostic challenge.

Case report

A 45-year-old woman presented with unilateral hearing loss, tinnitus, vertigo and otalgia. Examination was unremarkable. Audiometry demonstrated a left-sided, 30 dB conductive hearing loss. Tympanometry revealed a type C trace. On review 12 months later, the patient's vertigo and tinnitus had progressed, and she had developed sensorineural hearing loss.

Radiological findings

Initial magnetic resonance imaging demonstrated 'signal drop out within the left horizontal semicircular canal' and a petrous apex effusion. Subsequent computed tomography demonstrated a soft tissue mass eroding the labyrinth and distorting the external ear canal.

Management

Mastoid exploration revealed a homogeneous, pale, granular tumour. Frozen section analysis suggested chronic inflammation. Due to the lesion's destructive nature, complete resection was performed via a subtotal petrosectomy.

Histological findings

Formal histopathological examination showed fibrotic tissue with inflammatory and bland spindle cells involving soft tissue and bone. Lymphocytes and plasma cells were the predominant cellular infiltrates. Immunohistological staining was positive for smooth muscle actin. Staining for lymphoma, epithelium and mesenchyme was negative. The immunohistological profile was most consistent with an interdigitating reticulum cell tumour, a variant of histiocytosis.

Conclusion

Dr Connor emphasised the benefit of dual imaging of temporal bone lesions. Professor Michaels was wary of contradicting the diagnosis in the limited time available. However, he suggested that the likely diagnosis was either chronic inflammatory change or lymphoma. Subsequent formal histological review concluded that the lesion was an immunoglobulin G4 pseudotumour, a diagnosis which explained the destructive nature of this apparently inflammatory lesion.

Unexplained pigmented lesion on the tympanic membrane in a patient with vertigo

J C Williams, A M D Bennett, A A Orabi
From Norfolk and Norwich University Hospital

Introduction

We present a case of an unexplained lesion on the tympanic membrane in a patient with long-standing episodic vertigo.

Case report

A 35-year-old man presented with a 15-year history of intermittent vertigo, occurring spontaneously once or twice a year, lasting for days, associated with nausea and bilateral aural pressure. He had no history of previous trauma, or cautery or surgery to the ear.

The only finding on otoneurological examination was a dark macular lesion on the right tympanic membrane. Audiometry and tympanometry were normal.

Tympanotomy revealed a pigmented lesion involving the tympanic membrane, ear canal and chorda tympani. The rest of the middle-ear cleft was normal.

Radiological findings

A magnetic resonance imaging scan of the internal auditory meatus and a computed tomography scan of the temporal bones showed no abnormality.

Histological findings

The specimen was a 0.4 cm piece of black tissue. The tympanic membrane was thickened with fibrous tissue (without calcium deposits), and there was an infiltrate of inflammatory cells. There were large, inorganic, black deposits of partly birefringent material. Professor Michaels commented that it did not look like melanin pigment, but rather like the amalgam tattoos (created by metal dust) occasionally seen in the oral mucosa. Mr T Aymat had seen a similar appearance on the tympanic membrane after holistic ear candle therapy. Mr A Fitzgerald O'Connor had once received a histology report commenting on metallic pigmentation in a biopsy of the endolymphatic sac. It had been concluded that this probably resulted from the effects of the mastoid drill on the metallic tip of the suction catheter.

Giant retropharyngeal lipoma of the neck: case report

H Pope, N Gibbins, T Jacob
From University Hospital Lewisham, London

Introduction

We present a patient with a giant, asymptomatic, retropharyngeal lipoma discovered as an incidental finding, which complicated the presenting complaint of bilateral neck abscesses.

Case report

An 84-year-old woman was admitted from the out-patient department with a non-healing, left-sided neck wound, following open biopsy of a neck mass, and a new, right-sided neck mass. The patient had multiple co-morbidities, including breast cancer, and, notably, had travelled widely in the past. Examination revealed generalised swelling of the neck, a non-healing left-sided neck wound, and a right-sided, level II neck lump.

Radiological findings

Ultrasonography of the neck showed the initial non-healing mass and a low-density, ill-defined area in level II of the right side of the neck. Computed tomography of the neck revealed marked lipomatosis between the cervical spine and trachea, massively distorting the soft tissues of the neck.

Management

Management was conservative. Surgical intervention was not considered as the lipoma was asymptomatic and the patient had several co-morbidities. Her associated diagnosis was tubercular neck abscesses colonised by *Burkholderia cepacia*, complicated by immunodeficiency from her breast cancer.

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Conclusion

Giant retropharyngeal lipomata usually present with the gradual onset of compressive symptoms such as dysphagia, dysphonia, dyspnoea and obstructive sleep apnoea. We present an incidental finding of a giant, asymptomatic, retropharyngeal lipoma managed conservatively. Dr S Connor commented that radiology could not differentiate between a benign lipoma and a mature liposarcoma. Dr Sandison commented that cytology would also be of no value, as the tissue architecture needed to be assessed. Mr Shukla (Mumbai) commented that he had performed liposuction of a similar lesion, found to be benign.

Paediatric session

Chairman: Miss Hanna Burns

An unusual cause for nasal airway obstruction in a neonate

R Steven, M Rothera, I Bruce
From the Royal Manchester Children's Hospital

Introduction

Neonates are obligate nasal breathers. Nasal obstruction in this period may have serious implications. We present an extremely rare cause of nasal obstruction in the neonatal period.

Case report

An eight-day-old male infant was transferred to our tertiary centre for further assessment of upper airway obstruction. Initial investigations at the referring hospital had revealed no obvious cause for the child's respiratory distress. A direct laryngotracheal bronchoscopy was undertaken; this showed a large, cystic lesion which appeared to arise from the roof of the post-nasal space.

Radiological findings

Computed tomography and magnetic resonance imaging showed a basal cephalocoele projecting down into the oropharynx, with an intracranial connection to the pituitary fossa.

Management

Transpalatal excision of the nasopharyngeal cephalocoele was undertaken, together with closure of the intracranial connection and repair of the palate. A lumbar drain was inserted. Post-operative recovery was uneventful, with no evidence of cerebrospinal fluid leak.

Histological findings

Histology showed fibrovascular tissue, lined on one aspect by respiratory-type epithelium containing mucous glands. The core contained multiple cystic spaces lined by choroid plexus epithelium. Glial tissue was present in the walls of the mass. Dr Sandison noted that this does not necessarily mean that brain tissue was included in the hernia, and felt that the pathogenesis was uncertain.

Conclusion

To our knowledge, there have been few previous reports of a trans-sellar, trans-sphenoidal cephalocoele presenting in a neonate. Thorough pre-operative assessment by a multidisciplinary team is essential for surgical planning. A transpalatal approach gives excellent surgical access, whilst avoiding the morbidity and mortality associated with an intracranial approach.

An unusual looking solitary polyp of the nasal cavity

P Kirkland, S Baer, S Cartwright
From the Conquest Hospital, Hastings

Case report

A 16-year-old girl presented to the ENT out-patients department with symptoms of right-sided nasal blockage, rhinorrhoea and cacosmia over the preceding five months. On examination, a polyp was visualised arising from within the right nasal cavity.

Radiology

An initial magnetic resonance imaging scan demonstrated a lesion centred within the nasal cavity and extending into the maxillary antrum. A computed tomography scan demonstrated a large, right-sided nasal polyp with thinning of the bony wall of the antrum.

Management

The patient underwent endoscopic sinus surgery and nasal polypectomy. Intra-operative bleeding from the sphenopalatine region was controlled with diathermy.

Histology

Macroscopically, the polyp tissue was dark tan, hard and bone-like in nature.

Microscopically, the polyp was composed of small, bony trabeculae set in a cellular and vascular fibrous stroma. The trabeculae demonstrated osteoblastic and osteoclastic activity, and a diagnosis of osteoblastoma was made. Dr Sandison could not see any evidence of bony invasion, and felt that the tumour was likely to represent a fibro-osseous inflammatory lesion.

Conclusion

Osteoblastomas account for approximately 3 per cent of all bone tumours. Of these, only 15 per cent occur in the head and neck region. Less than 10 case series have been reported, all involving patients aged less than 30 years.

Infantile stridor in a child with a supraclavicular mass

J Goswamy, M P Rothera, I A Bruce
From the Royal Manchester Children's Hospital

Introduction

We present a rare cause of stridor in an infant, highlighting the importance of thorough investigation and surgical planning.

Case report

A six-month-old male infant presented to the emergency department with a persistent cough and inspiratory stridor at rest. Medical management failed, and an expanding mass in the supraclavicular fossa was noted. The working diagnosis was a cervico-thoracic cystic hygroma.

Radiological findings

A computed tomography scan revealed a cystic lesion extending from the carina to the hyoid bone and causing significant tracheal compression.

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Histological findings

Histopathological analysis of the specimen showed a bronchogenic cyst.

Management

A multidisciplinary approach was used to formulate the most appropriate management plan. Significant airway compromise was demonstrated during rigid airway endoscopy. Complete surgical excision was performed via a transcervical approach, with support from a thoracic surgeon on standby. The child was extubated successfully 11 hours post-operatively, and made an uneventful recovery. Two weeks later, the child's stridor had almost completely resolved.

Lessons learned

Bronchogenic cysts are a developmental malformation resulting from abnormal foregut budding during embryological development. They are usually found in the thoracic cavity. The usual presentation is with a mass effect and subsequent recurrent respiratory infections. Surgical excision is the treatment of choice, notwithstanding the risk of significant and potentially life-threatening complications. Bronchogenic cysts should be considered in the differential diagnosis of a cystic mass in a child.

Facial swelling: it's not always mumps!

C A I Sweeney, B Pizer, R K Sharma

From the Alder Hey Children's NHS Foundation Trust, Liverpool

Metastatic neuroblastoma in the parotid region is uncommon.

A two-year-old boy presented with a 12-day history of an enlarging right cheek swelling, lethargy and poor feeding. He had a 5×5 cm parotid swelling which was firm and non-tender, with no associated erythema, facial nerve palsy or trismus. The buccal mucosa was deviated medially. Prior to presentation, it had been suspected that the swelling was secondary to mumps.

Investigations showed severe anaemia (haemoglobin 7.2 g/dl) together with an elevated lactate dehydrogenase (1565 U/l), C-reactive protein (178 mg/l) and erythrocyte sedimentation rate (113 mm/hour).

Urgent ultrasonography, magnetic resonance imaging (MRI) and computed tomography (CT) were performed, and an intra-oral biopsy was taken.

The ultrasound, MRI and CT all showed a $4.3 \times 4.2 \times 5.2$ cm swelling arising from and enveloping the right mandibular ramus, with bony destruction and cervical lymphadenopathy. An abdominal CT showed an $11 \times 10 \times 9$ cm, heterogeneous, suprarenal mass with an area of central necrosis. A nuclear medicine bone scan was normal.

The biopsy appearance was consistent with an undifferentiated, stroma-poor neuroblastoma (grade IV). Expression of the proto-oncogene N-myc was found; this is associated with a poorer prognosis.

The patient was entered into the International Society of Paediatric Oncology high risk neuroblastoma study.

Treatment included chemotherapy with G-CSF support, autologous stem cell transplantation and abdominal mass resection.

At the time of writing, the mass was $3.7 \times 1.7 \times 3$ cm. Further treatment was planned with high-dose chemotherapy, radiotherapy and immunotherapy.

A rare case of facial pain and otalgia in a child

G Pilgrim, S Peridis, C Hopkins

From Guy's and St Thomas' NHS Foundation Trust, London

Case report

An 11-year-old girl was referred for a second opinion, having had severe facial pain and otalgia for several years. Magnetic resonance imaging, performed at the initial hospital, had found only a small lesion in the sphenoid, which was thought to be incidental. Investigations were repeated three years later, after the child's symptoms failed to improve.

Radiological findings

Imaging revealed an expansile, $9 \times 8 \times 1$ cm mass involving the path of the right vidian canal. Dr Connor felt that this was likely to be an intrinsic bone lesion.

Management

Transnasal, trans-sphenoidal resection of the lesion, using an intra-operative localisation system, was achieved without complication. The patient's pain subsequently resolved.

Histological findings

Examination of the lesion revealed a fibrous bone lesion, without osteoclastic or osteoblastic activity or specific immunoreactivity. The preferred diagnosis was desmoplastic fibroma. Professor Michaels commented that the appearance of the lesion was highly unusual, and that identification of the specimen was challenging.

Conclusion

It would appear that desmoplastic fibroma was responsible for the child's symptoms.

Discussion

The meeting discussed whether the lesion should have been further assessed when it was initially identified. The consensus opinion was that, although it was easy in retrospect to criticise the labelling of the lesion as incidental, at that time there had been no suspicion that a small lesion at that site could cause the child's symptoms. These have been no previous reports of facial pain as a presenting feature of desmoplastic fibroma, although the vidian canal is a novel anatomical site.

Rhinology session

Chairman: Mr Tony Aymat

A nasal alar mass of unknown aetiology

Z Maan, G Yassin, A Rachmanidou

From University Hospital Lewisham, London

Introduction

Tumours of the nasal cartilage are rare. Lymphoid nasal masses are particularly so, being generally attributed to underlying immunological dysfunction. Such masses can be benign or malignant.

The photographic, radiological and histological findings of an atypical lymphoid nasal mass are presented, and the relevant literature reviewed.

Case report

A 32-year-old woman presented with left-sided nasal obstruction, hyposmia and intermittent left-sided facial swelling. Significant past medical history comprised nasal injury two years previously. Examination revealed a 10×7 mm, tender, left-sided nasal mass, which appeared to arise from the soft tissue of the alar region.

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Radiological findings

Computed tomography (CT) showed mild mucosal thickening of the left frontal sinus. Magnetic resonance imaging demonstrated a soft tissue mass over both the upper and lower left alar cartilages, extending into the nasal cavity. Post-operative CT demonstrated a persistent soft tissue swelling at the left nasal alar region.

Management

The mass was excised for diagnostic purposes and symptom relief. Post-operative collapse of the left ala was managed with injection of intra-dermal fillers.

Histological findings

The histological appearance was indeterminate. There was extensive lymphoid proliferation with associated fibrosis of uncertain significance. Review at a tertiary referral unit reported florid lymphoid infiltrate, with severe hyperplasia or 'mucosa-associated lymphoid tissue' lymphoma as differential diagnoses. Further testing demonstrated no evidence of monoclonal B cell population, and a tentative diagnosis of reactive lymphoid tissue was made.

Conclusion

The diagnostic challenges of this case highlight the need for a multidisciplinary approach to nasal lymphoid masses.

Non-tuberculous mycobacterial orbital cellulitis

E Noon, D Roberts, C Hopkins

From Guy's and St Thomas' NHS Foundation Trust, London

Case report

A 36-year-old Sudanese woman presented with acute orbital pain accompanied by visual loss, total ophthalmoplegia, proptosis and a discharging collection in the superolateral orbit. There was no significant medical history. Intranasal examination was unremarkable.

Radiology

Computed tomography demonstrated a left frontal sinus mucocele with a bony partition, which had eroded through the floor of the sinus laterally to form an orbital abscess.

Management

External drainage was performed. The resulting specimens were positive for acid-fast bacilli, although molecular tests proved negative for tuberculosis. Cultures later grew *Mycobacterium chelonae*, so the patient was commenced on clarithromycin and ciprofloxacin, following microbiology advice.

Despite initial clinical improvement, the patient later relapsed, at which point she revealed she was 12 weeks pregnant with twins, and had discontinued antibiotics. It was decided to surgically drain the collection under general anaesthesia, to prevent irretrievable visual loss. At this point, and in all subsequent specimens, smears for acid-fast bacilli were negative and culture did not reveal *M chelonae*.

There have been only four previously reported cases of this organism complicating sinus disease, and none involving the frontal sinus.

Discussion

Despite negative molecular testing for tuberculosis, given the patient's history of foreign travel associated with an erosive mucocele, we considered whether a diagnosis of tuberculosis should have been presumed from the outset, and agreed that it was likely that *M chelonae* was a contaminant. Mr Shukla (Mumbai) commented that a more extensive drainage procedure should have been performed. A more aggressive initial approach to the mucocele via a Draf III (rather than Draf II) procedure may have reduced the risk of recurrence.

An unusual case of epistaxis

J E K Sherman, A Ali, R J Hewitt

From Charing Cross Hospital, London

Introduction

Primary nasal malignant melanoma is a rare condition accounting for less than 1 per cent of all malignant melanomas. The treatment of choice is surgical resection. The prognosis is poor, with a high prevalence of local recurrence.

Case report

We present the case of a 50-year-old Hungarian man who initially presented to a district general hospital with a five-month history of recurrent left epistaxis, left nostril blockage, and facial pain in the region of the left maxillary antrum.

Imaging

Computed tomography (CT) and magnetic resonance imaging scans of the sinuses showed a 5.4 cm, soft tissue mass occupying the left nasal and maxillary cavities. This extended to involve the left periorbital tissue and the medial rectus. There was bony erosion of the left maxilla with palatal involvement. Positron emission tomography CT showed increased uptake in the cervical lymph nodes.

Histology

Initial histological review suggested a lymphoid tumour, but this was subsequently excluded as the cells were negative for lymphoid markers. The specimen was referred to a head and neck pathologist. Further immunostaining for epithelial, muscle and neuroendocrine markers was negative. There were scattered S100 and Melan A positive tumour cells and diffuse expression of HMb45 antigen, indicative of malignant melanoma.

Management

Craniofacial resection (for the sinonasal tumour) and selective neck dissection were performed. Post-operative radiotherapy was planned.

Conclusion

Occasionally, malignant melanoma does not express S100 or Melan A; in this case the panel of immunohistochemical markers should include HMb45. The presented case demonstrates the importance of early referral to a tertiary centre for head and neck pathology analysis, when the clinical picture and the histopathology do not correlate.

Left forehead swelling in a 27-year-old with a previous head injury

A Walker, A Toma

From St George's Hospital, London

Introduction

Pott's puffy tumour was first described in 1760 as osteomyelitis of the frontal bone secondary to head injury. In modern times, it has been described more frequently as a complication of frontal sinusitis in children, with a declining incidence due to the advent of antibiotics.

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Case report

A 27-year-old man presented with classical Pott's puffy tumour secondary to sinusitis, following a previous history of frontal bone fracture. The patient presented with a two-day history of left forehead and periorbital swelling, plus some preceding mild coryzal symptoms, but no symptoms of sinusitis. Five years previously, he had sustained a frontal bone fracture. He had previously suffered one similar episode of orbital cellulitis, which had settled with conservative management.

On examination, he had pronounced left periorbital cellulitis, with proptosis. Eye examination revealed mild diplopia, although colour vision was intact.

Radiology

Computed tomography scanning demonstrated a soft tissue collection lying anterior to the left orbit, which communicated with the frontal sinus via the previous fracture site, and mucosal oedema of the ethmoid and frontal sinuses.

Management

After consultation with our ophthalmology colleagues, it was decided to trial a short period of conservative management. Within 24 hours, the patient's swelling began to improve, and it settled completely within four days.

This case report highlights the association of Pott's puffy tumour with previous trauma, the requirement for a multidisciplinary management approach, and the treatment possibilities.

Unilateral nasal obstruction: an unusual cause

A Walden, M Bentley, C East

From the Royal National Throat, Nose and Ear Hospital, London

Introduction

Unilateral nasal obstruction has a plethora of aetiologies. When coupled with ipsilateral hearing loss, it is important to rule out a post-nasal-space mass. We present a case of a rare nasal tumour, with interesting histological and radiological findings, in an otherwise fit and healthy young man.

Case report

A 30-year-old man presented with a longstanding history of right nasal obstruction and decreased hearing on the right. Endoscopic examination revealed a large, red, inflamed mass in the right nasal cavity, extending into the post-nasal space. The patient underwent urgent computed tomography and subsequent post-nasal-space biopsy.

Radiological findings

Computed tomography sinus scans and magnetic resonance imaging scans with contrast both showed a right-sided, soft tissue nasal mass obstructing the posterior choana and sphenoethmoidal recess. There was secondary mucosal thickening in the right posterior ethmoidal air cells and sphenoid sinus.

Histological findings

A provisional diagnosis of spindle cell tumour was made. Dr Sandison commented that the differential diagnosis included a synovial sarcoma, but that immunocytochemistry confirmed a malignant peripheral nerve sheath tumour (Trojani grade 1) arising from a neurofibroma.

Management

The patient underwent endoscopic clearance of a right nasoethmoidal tumour, together with a right-sided grommet insertion. After discussion by the multidisciplinary team, it was decided to monitor the patient. At the time of writing, there had been no sign of recurrence.

Conclusion

There are numerous benign and malignant nasopharyngeal masses. The presented patient had an interesting presentation of a rare tumour requiring careful consideration of treatment modalities, due to its aggressive nature and high risk of recurrence. Approaching such cases in a multidisciplinary setting will assist diagnosis and management.

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