CASE PRESENTATION

DR NITYA
1ST YEAR PG
DEPT. OF ENT

Name – Ch.Balaiah

Age – 60 yrs

Sex- male

Occupation – farmer

Residence - Nalgonda dist.

DOA – 28-12-15

- CHIEF COMPLAINTS:
  - Swelling in the left forehead since 1 month
  - Left facial pain since 15 days

- HOPI

  -Patient was apparently asymptomatic 1 month back and then developed a diffuse swelling in the left forehead

  -Insidious in onset and gradually progressive

  -No aggravating and relieving factors

  --c/o left facial pain since 15 days which was severe throbbing type continuous with no aggravating & relieving factors

  -a/w left unilateral frontal headache throbbing type n/a/w nausea and vomiting

-a/w 1 episode of bleeding from nose from the left 15 days back

- Precipitated with nose picking, minimal in quantity, lasted for few minutes and subsided spontaneously

-a/w blurring of vision

-a/w fever which was low grade intermittent not a/w chills and rigors

-a/w mouth breathing and snoring

-No h/o allergic symptoms, postnasal drip

-No h/o trauma

-No h/o ear pain, decreased hearing, ringing sensation, aural fullness

-No h/o double vision

- No h/o sore throat, change of voice, difficulty in swallowing

-No h/o cough, shortness of breath

-

- PAST HISTORY :

  - No similar c/o in the past

  -No h/o any drug allergies and Radiation exposure

  -N/K/C/O DM, HTN, TB, BA,CAD, Epilepsy

  -No h/o previous surgeries

- PERSONAL HISTORY :

  -Diet : Mixed

  -Appetite : Normal

  -Bowel & bladder : Regular

  -Sleep : Disturbed

-He is a known smoker since 40 years smoking 2 packs per day and stopped 2 yrs back

-No h/o tobacco chewing

-No addiction to alcohol

- FAMILY HISTORY :

  - No similar c/o in the family

GENERAL EXAMINATION

- Patient is moderately built and nourished
- He is conscious, coherent with respect to time and space
- Vitals – PR- 84/min

  BP- 110/70 mmHg

  CVS – S1 S2 heard, no murmurs

  RS – BAE, No adventitious sounds heard
- Pallor (+) , No icetrus,cyanosis,koilonychia, lymphadenopathy ,clubbing, pedal oedema

LOCAL EXAMINATION

- **O/E FACE: INSPECTION**

  - Facial asymmetry present

  -Diffuse 6x4 cm swelling present in the Left supraorbital region

  -Extending horizontally from the midline to the left temple

  -Superiorly from middle of the forehead to just below the left orbital rim

-Skin over the swelling normal

- Two vertical scars + over the medial end of (L) eyebrow

-No fistulas or sinuses seen

-No dialated or engorged veins or transmitted pulsations seen

-Intercanthal distance widened

-Ptosis of the left upper lid (+)

- (L) Proptosis +

-No conjuctival congestion ,incomplete eye closure or restricted ocular mobility

- No signs of facial N weakness

PALPATION :

-Inspectory findings confirmed-Tenderness over the swelling (+)

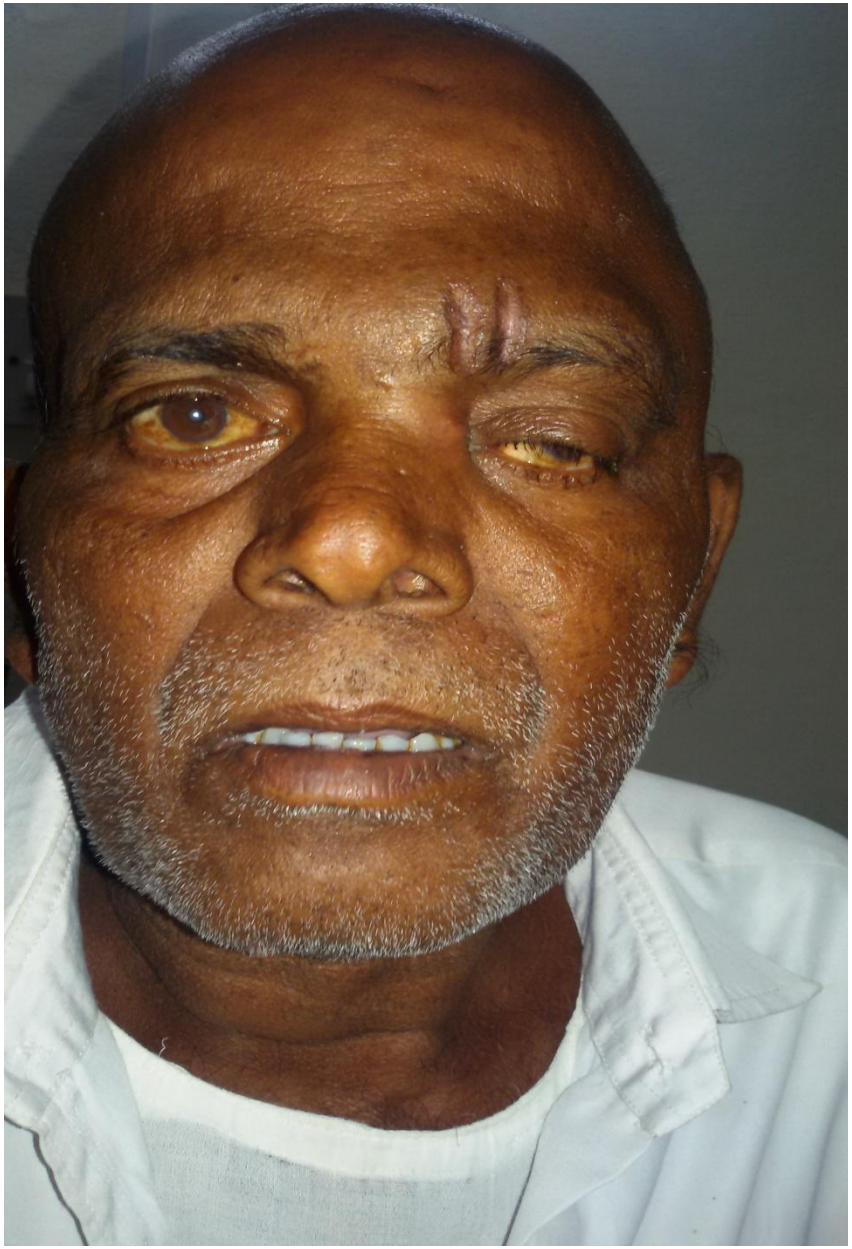
-Crepitus (+)

-No local rise of temeprature

-Soft in consistency, compressible

-Not mobile

-Skin is pinchable



-Fluctuation absent, translucency -ve

- O/E **NOSE**:

  -External framework- broading of the root of the nose seen

  -Vestibule, columella-Normal

  -**Anterior Rhinoscopy**- Black, hard , irregular crusts present filling the entire left nasal cavity and over the septum; turbinates, roof and floor not seen on the left

-Right nasal cavity severely narrowed and septum, turbinates, floor, roof cannot be identified

-**Posterior Rhinoscopy**- B/L choana filled with crusts; posterior end of the turbinates and septum not identified

-**Cold spatula test**- reduced misting b/l

-Left maxillary, ethmoidal and frontal sinus tenderness (+)

- O/E **EAR**

	RIGHT	LEFT
PINNA	Normal	Normal
EAC	Clear	Clear
TYMPANIC MEMBRANE	Intact	Intact

- O/E **ORAL CAVITY**:

  -No trismus

  -Lips – Normal

  -GL,GB sulcus- Normal

  -Gingivitis (+)

  -Nicotine staining of teeth (+)

  -Anterior 2/3rd tongue-Normal

  -Hard palate-Normal

  -Floor of the mouth - Normal

  -Retromolar trigone-Normal

- O/E OROPHARYNX:
  -Anterior pillar
  -Tonsil
  -Posterior pillar
  -Soft palate Normal
  -Uvula
  -Posterior 1/3rd tongue
  -Posterior pharyngeal wall

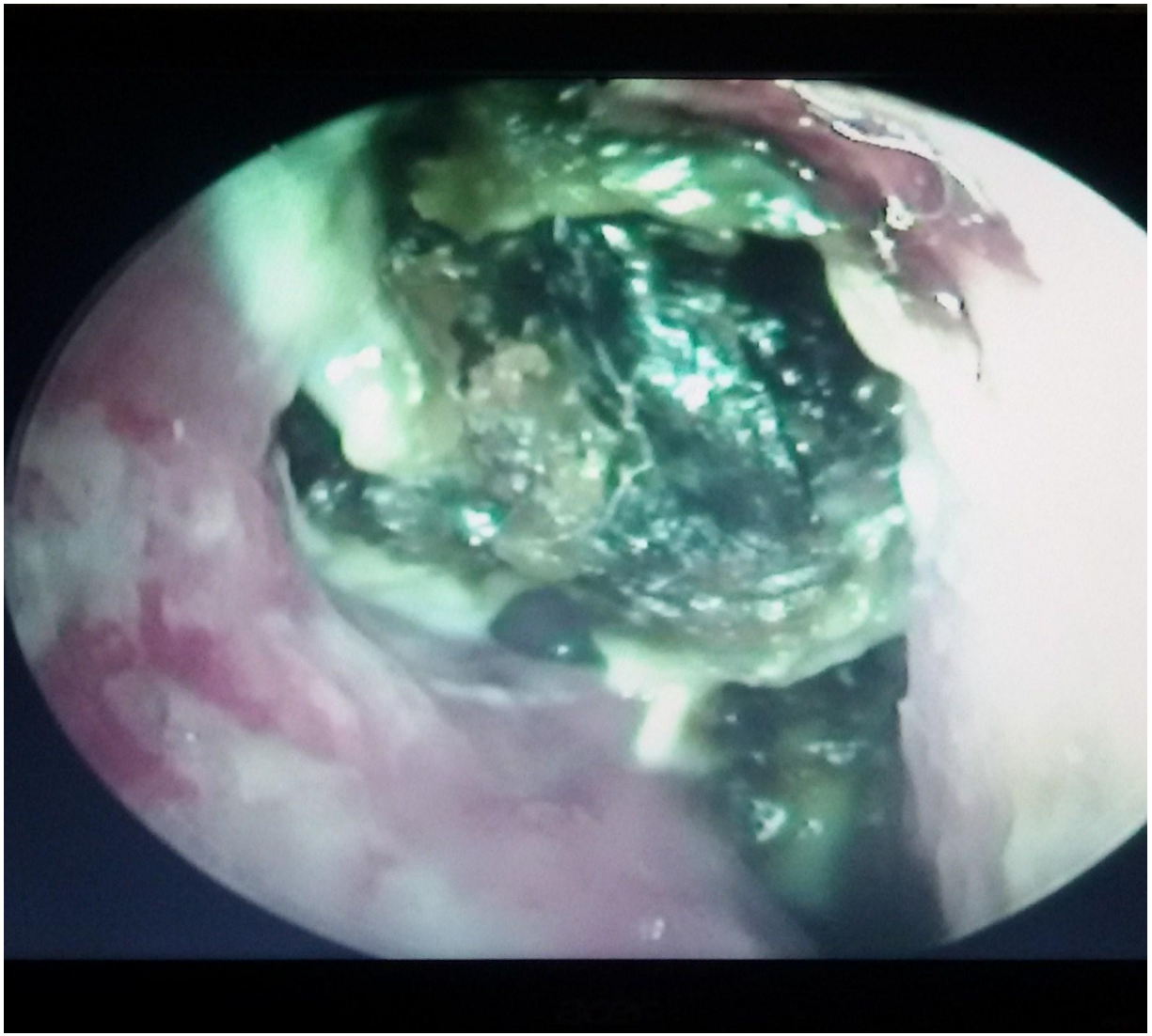
- O/E NECK :

  -No other swellings seen

  -No palpable lymphadenopathy

DIAGNOSTIC NASAL ENDOSCOPY

- Hard dark greenish black crust found in the left nasal cavity
- Crusts cannot be removed and an attempt to remove precipitated bleeding
- Right nasal cavity is severely narrowed and endoscope could not be passed



INVESTIGATIONS

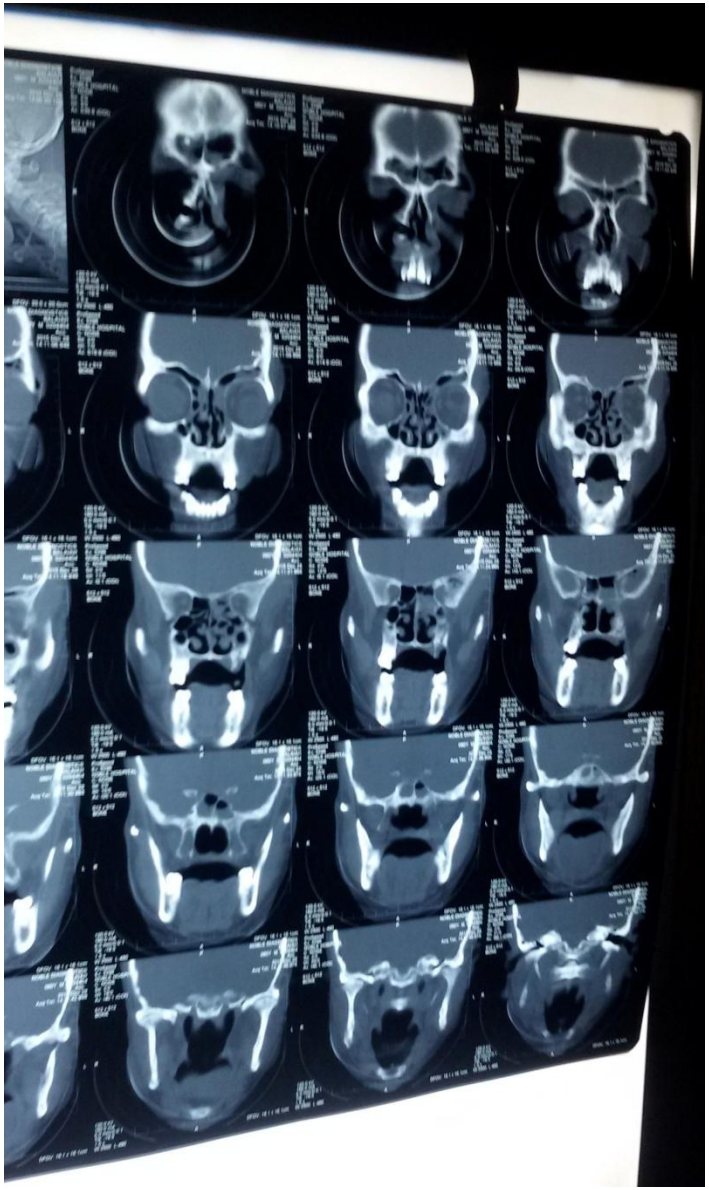
- CBP :
  -Hb : 12.4%
  -TLC : 11,800/cubicmm
  -Neutrophils : 54%
  -Lymphocytes : 42%
  -Eosinophils : 2%
  -Monocytes: 2%
  -Basophils : 0%
  -Platelet count : 2.53 lakhs/cubicmm
  -Blood group : B +ve
  -BT : 2 min
  -CT : 4 min

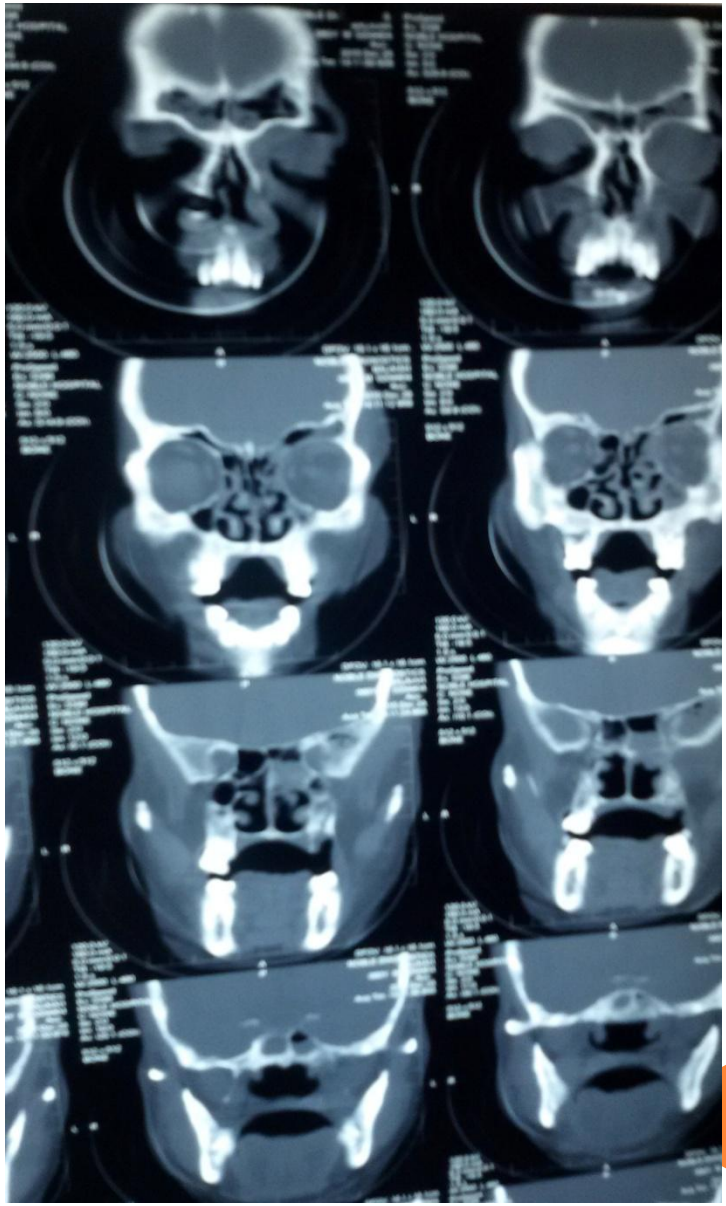
- APTT : 32
- PT : 16
- INR : 1.1
- RBS : 144 mg/dl
- Blood Urea : 50 mg/dl
- Serum creatinine : 1.6 mg/dl
- S.Na+ : 139 mmol/L
- S.K+ : 4.2 mmol/L
- S.Cl : 100 mmol/L
- CUE : Normal study

- Chest X Ray PA view : Normal study
- ECG : Normal study
- USG Abdomen was reported as -Grade 1-2 Renal parenchymal disease

CT PNS

- Soft tissue density occupying the left nasal cavity
- Bony septum absent
- IMPRESSION: **Pansinusitis with ? Septal perforation**





PROVISIONAL DIAGNOSIS

- Pott's puffy tumor (fronto-ethmoidal oseteomyelitis)
- Atrophic rhinitis
- Granulomatous lesion of nose

MEDICAL MANAGEMENT

- Patient was on broad spectrum antibiotics and analgesics:

  -Inj Monocef 1gm IV BD

  -Inj Metrgyl 100 ml IV TID

  -Inj Voveran 75 mg IM BD

  -Inj Rantac 50mg IV BD

- Patient was referred to the Ophthalmologist in view of Left ptosis and proptosis
- There findings were:

  -Proptosis of left eye according to LEUDDE EXOPHTHALMOMETER:

  Right eye reading : 14mm

  Left eye reading : 23mm

  -Ptosis: MRD 1= 1 mm

  MRD 2= 4 mm

  PFW = 7 mm

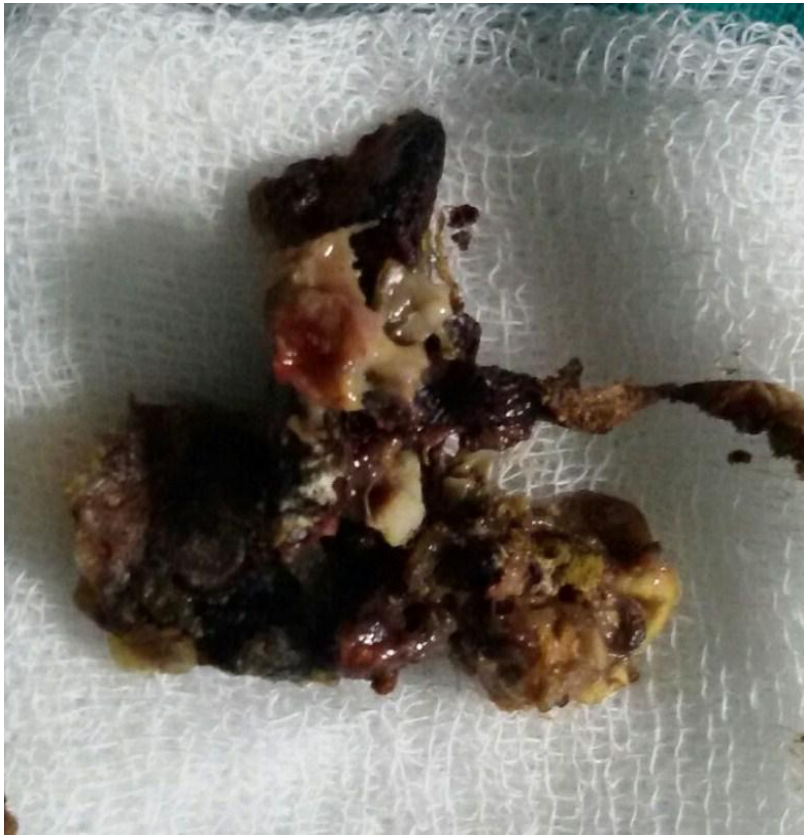
- Patient was referred to the Nephrologist in view of Renal parenchymal disease as per USG abdomen and elevated B.Urea levels
- No active intervention was suggested

SURGICAL MANAGEMENT

- After the Pre anaesthestic checkup patient was posted for Functional nasal endoscopic sinus surgery under GA
- Under all aseptic conditions patient was placed in a supine position with 15degree head end elevation
- Stony hard crusts found in both the nasal cavity and removed
- Large septal perforation noted involving the entire septum except the caudal end of the cartilagenous septum

- Lateral wall of the left nasal cavity eroded along with lamina papyracea
- No turbinates identified
- Granulations + under the crusts seen after the crust removal involving the ethmoidal cells, sphenoid sinus and lamina
- Frontal beak was found eroded and both frontal sinuses filled with pus & sequestrum which was cleared
- Haemostasis secured
- Anterior nasal packing done with soframycin soaked ribbon gauze
- Patient shifted to the Post-OP in a stable condition

- The granulations found after the removal of the crust was sent for histopathological examination



POD - 0

- Anterior nasal pack present , No soakage, No post nasal bleed
- 15 degree head end elevation
- IVF- 1DNS & 1RL @ 100 ml/hr
- Inj Monocef 1 gm IV BD
- Inj Metrogyl 100 ml IV TID
- Inj Deriphyllin 1amp IV Stat
- Inj Decadron 8 mg IV BD
- Inj Tranexamic acid 1 amp IV SOS
- Inj Voveran 75 mg IM BD
- Inj PAN 40 mg IV OD BBF
- T.Levocetrizine 5 mg HS

POD - 1

- Patient c/o pain over the Left frontal area
- Proptosis reduced
- Pack removal done
- No active/postnasal bleed
- Swelling over the (L) frontal area reduced

- Inj Monocef 1 gm IV BD
- Inj Metrogyl 100 ml IV TID
- Inj PAN 40 mg IV OD BBF
- Inj Tramadol 50 mg IV BD
- Inj Deriphyllin IV BD
- Inj Decadron 8 mg IV BD
- Inj Tranexamic acid IV SOS
- Otrivin N/D 3 drops TID
- Flutirest Nasal spray 2puffs twice daily

POD – 2,3

- Patient c/o left frontal headache
- Proptosis and ptosis of (L) eye reduced
- Swelling over (L) frontal region reduced
- Mucous plugs present in the (R) nasal cavity +
- Same treatment was continued
- Saline nasal douching advised 2-3 times daily

POD - 4

- Patient had no fresh complaints
- He was advised

  -Liquid paraffin drops instillation in the nasal cavity

  -Glucose + glycerine paste for L/A

  -T. Prednisolone given as 1mg/kg in divided doses

  -Alkaline nasal douching with Soda bicarbonate (2), Sodium biborate (2) and Sodium chloride (1)
- Rest of the analgesics and antibiotics were continued along with the steroid nasal spray

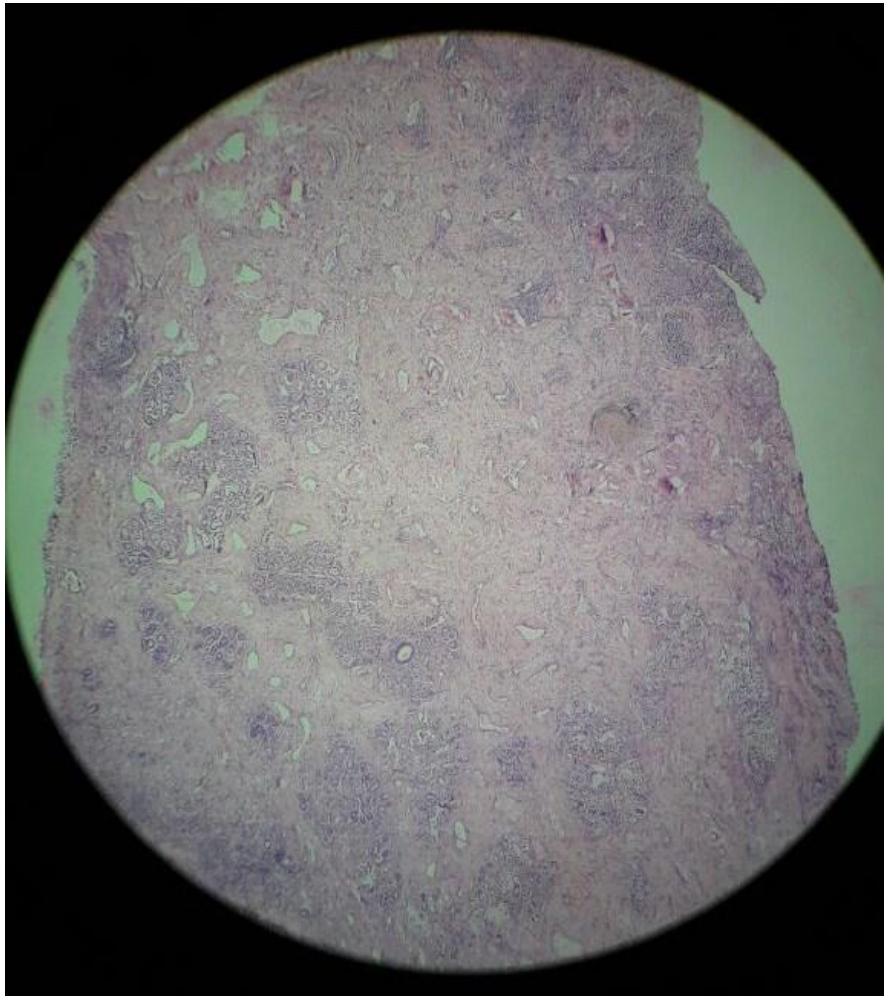
POD -5,6

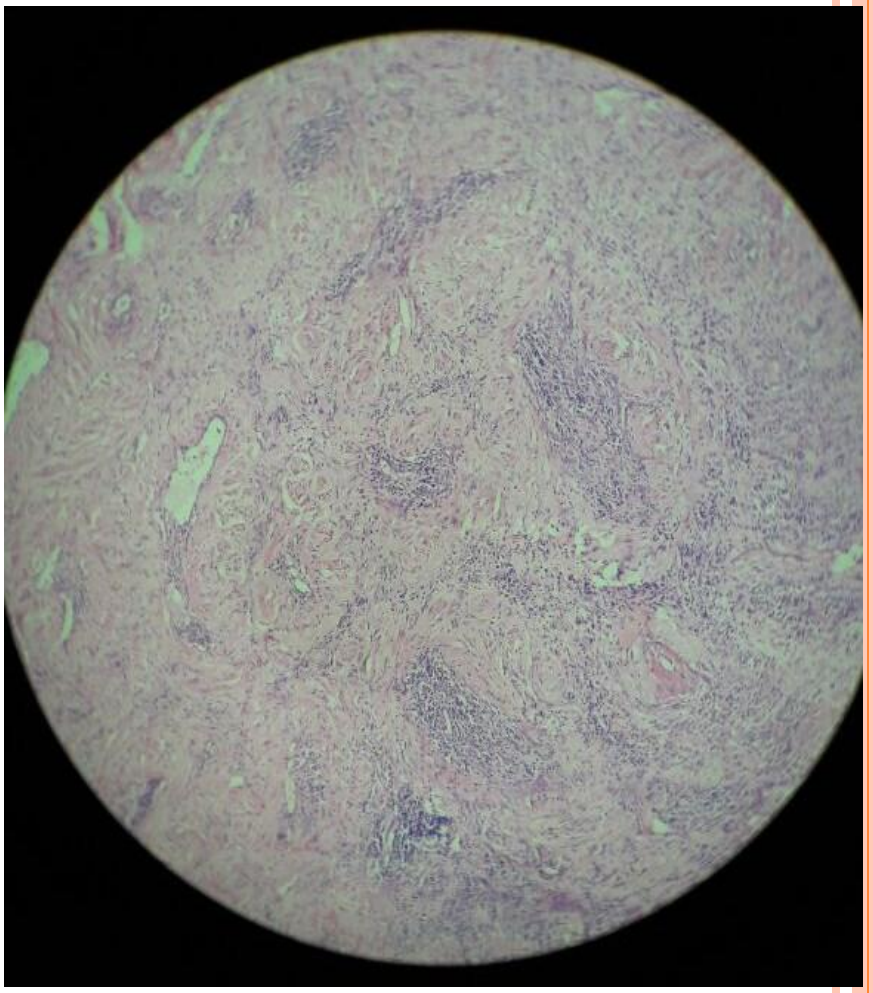
- Were uneventfull
- Same treatment was continued

POD - 7

- Patient had no fresh complaints
- Received the histopathological reporting of the granulations sent intraoperatively

HISTOPATHOLOGICAL EXAMINATION





HPE REPORTING

- Features suggestive of WEGENER's GRANULOMATOSIS a/w seromucinous glandular hyperplasia

- Upon the histopathological reporting suggestive of WEGENER's granulomatosis, Patient was advised to test for c-ANCA and p-ANCA at a higher centre
- He was then discharged with the following treatment:

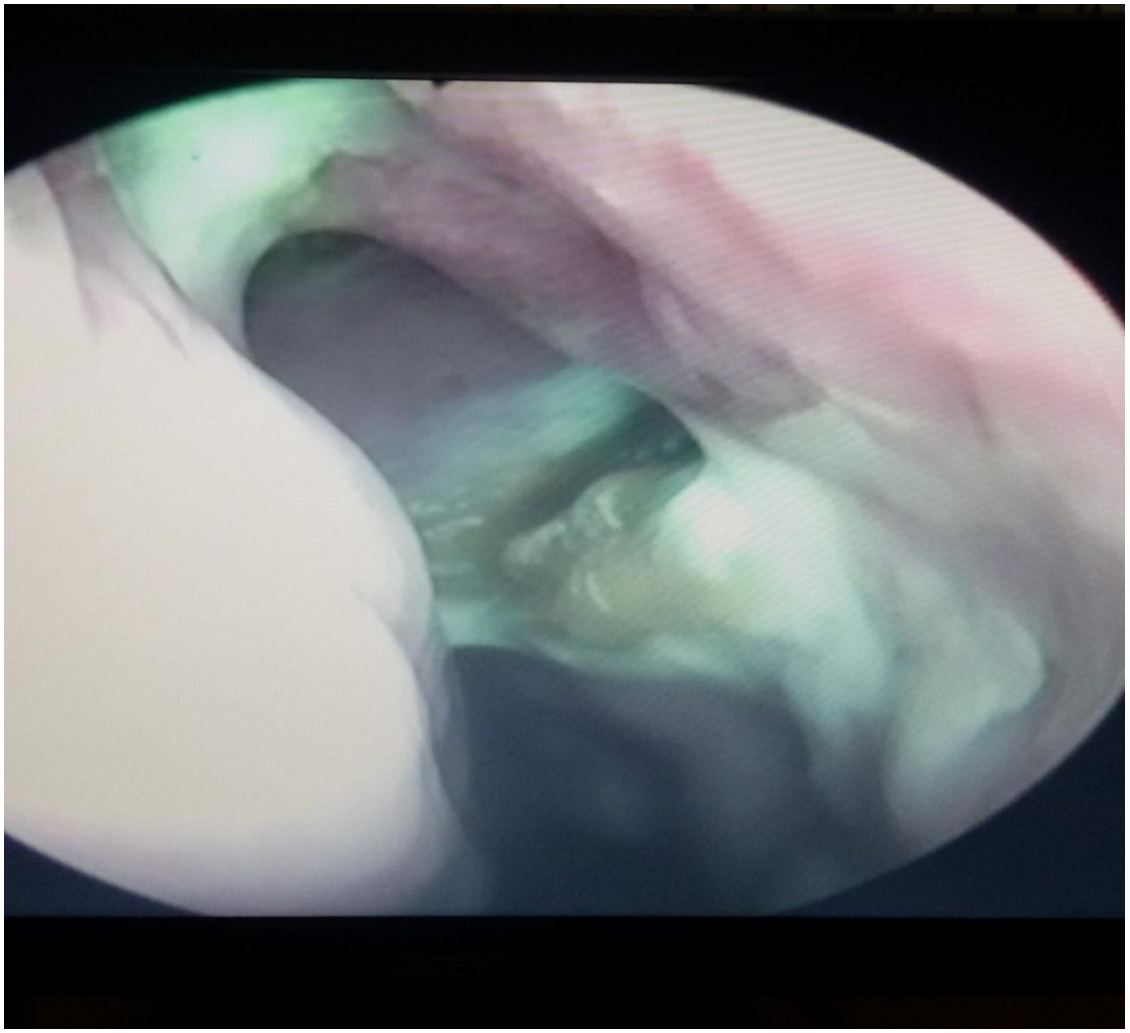
  -T. Prednisolone 30 mg BD for 10 days

  -Alkaline nasal douching 2-3 times daily

  -Flutirest nasal spray 2 puffs twice daily
- Patient was asked to review with reports of the above mentioned investigations

- Patient was reviewed in the OP 1 week later
- He had no fresh complaints
- However he did not go to the higher centre to check for the specific markers i.e, ANCAsdue to financial constraints

POST-OPERATIVE DNE

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ngiyabonga
teşekkür ederim
спасибо
dank je
thank you
gracias
tapadh leat
bedankt
hvala
mauruuru
mochchakkeram
dziękuję
go raibh maith agat
obrigado
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