

Sinus tumour

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ABSTRACT

Objectives: Cholesteatoma is a relatively common disease entity within the middle ear cavity, but it is rarely found in the paranasal sinuses, making interesting the differential diagnosis of unilateral sinus masses. It is most often located in the frontal sinus, less commonly in the ethmoids and maxillary sinuses. **Methods:** We present a middle-aged woman presenting with right nasal obstruction with bleeding that refractory to medical treatment. Fiberscopy exhibits an easily bleeding whitish mass, computed tomography (CT) scan shows a relatively homogeneous, expansile lesion with bony eroding. Elevation of serum SCC antigen is notified. **Results:** Biopsy under local anaesthesia was scheduled. The keratin-like material filled the whole antrum that could be easily removed by suction. The medial antral wall and inferior turbinate were absent. Findings of the histologic review were consistent with cholesteatoma without malignant cells. Post-operative MRI revealed no existing lesion. **Conclusions:** Cholesteatoma of paranasal sinus is extremely rare and may have symptoms mimicking other intranasal neoplasms. CT scans often present an expansile lesion with sharp circumscribed bony defect with smooth margin. Differential diagnosis includes both benign and malignant paranasal lesions. The appropriate treatment for cholesteatoma is surgery. Adequate drainage and sinusostomy for post-operative follow-up are recommended.

Case report: a rare case of primary extranodal laryngeal non-Hodgkin lymphoma

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ABSTRACT

Lymphoma is generally a nodal disease and arises from lymphoid tissues and organs. Extranodal lymphoma accounts for 30-40% of malignant lymphomas with gastrointestinal tract and cutaneous lymphomas top of the list. Squamous cell carcinoma accounts for 90% of laryngeal carcinoma while only 1% of laryngeal carcinoma is attributed to extranodal Non-Hodgkin Lymphoma (NHL). Only about 100 of such cases been reported in literature since 1952. As to our best knowledge, no such case was ever reported in our local literature. We are reporting a case of primary extranodal Non-Hodgkin Lymphoma of the larynx in our centre. The incidence, presentation, and management are discussed. A 58-year-old gentleman, an ex-intravenous drug user and active smoker, presented with one-month history of progressive hoarseness and worsening dysphagia but without respiratory symptoms. There was no history of neck mass, trauma or previous surgeries. He was negative for HIV. He underwent an elective tracheostomy under local anaesthesia due to airway compromise. Endoscopic, radiological and histopathological investigations revealed Non-Hodgkin Lymphoma of Diffuse Large B- cell subtype at left false cord extending to left arytenoid, left valleculae and left laryngeal surface of epiglottis. Unfortunately, the patient succumbed to hospital acquired pneumonia (HAP) on post-operative day-3. Extranodal Non-Hodgkin lymphoma in the context of ENT usually affects salivary glands, paranasal sinuses and thyroid gland. Larynx has very little lymphoid tissues compared to gastrointestinal and respiratory tract. Hence, the low incidence rate. Due to limited number of cases, no proper and definitive management guidelines, success rates and prognosis have been published. Modalities of treatments are concurrent chemoradiotherapy or just radiotherapy. Primary extranodal laryngeal Non-Hodgkin lymphoma has rather high 5-year disease-free rate except for the mantle cell lymphoma subtype which is very aggressive and poor prognosis.