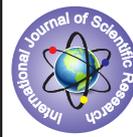


RECURRENT SINONASAL SCHWANNOMA



ENT

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ABSTRACT

- Schwannoma are neurogenic tumors which are rarely found in the nose and paranasal sinus.
- A 65 year old male presented with chronic rhinosinusitis affecting his right nose.
- He had history of transnasal oral surgery for same problem. Histopathology report suggestive of schwannoma.
- It is positive for SOX-10 and S-100. The lesion was removed by endoscopic sinus surgery with debridement.
- The patient made a good post-op recovery and remained disease free at 6 months follow up.

CASE PRESENTATION:

• A 62 yrs male was referred to VSGH In June 2015 complaining of recurrent Swelling near right eye, nasal bridge And watering from right eye with Anosmia. His prior surgical history of Nasal surgery at a different facility.

• O/E : 3x3 cm² swelling on medial canthus of right eye extending to dorsum of nose, non tender, non warm, firm in consistency, nasal septum pushed to left side and lobulated mass seen in right nasal cavity.

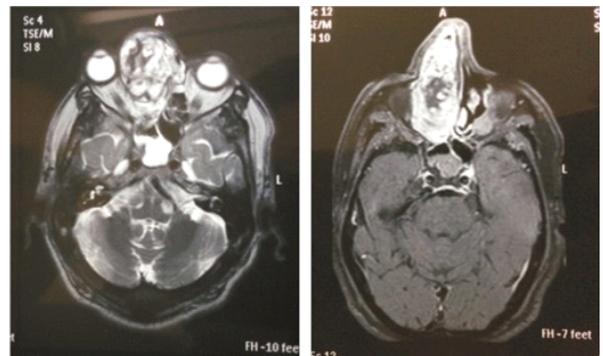


- Ophthalmic evaluation finger counting present both side of eye more than 3feet
- CT scan PNS with contrast: 76x28 mm well defined lobulated mass showing heterogeneous post contrast enhancement located in right nasal cavity. Superiorly lesion extend to right ethmoid ,left anterior ethmoid, bilateral frontal and laterally right maxillary, posterior into right ethmoid and bilateral sphenoid, right lamina papyracea is bowed laterally. Right cribriform plate and anterior skull base is appeared destroyed.



- MRI brain: 63x38x65 mm expansile mass lesion showing heterogeneous on T1W and T2W sequence. The lesion caused mass effect in the form of lateral bowing of medial wall of right orbit. Compress the right medial rectus and eye ball. Nasal

septum displaced to left side. Superiorly abutting the floor of an cranial fossa inferiorly up to right hard palate. Bilateral optic nerve normal.



- No intracranial involvement.
- On HPE examination spindle cell neoplasm with moderate to marked nuclear atypia and on IHC SOX-10 and S-100 positive.
- Surgical excision under GA was planned. Complete debridement of mass by endoscopic Trans nasal approach. Surgical kept over exposed Dura follow by Merocell and Abgel. Tissue sent for HPE examination and same finding As S/o previously HPE report.
- On 6 months follow up no CSF leak was found.

DISCUSSION:

- Schwannoma are benign, well encapsulated solitary neoplasm, which develop from Schwann cell that comprises the neural sheath of peripheral nerve fiber. Origin of sinonasal schwannoma is presumed to be the ophthalmic and maxillary branches of the trigeminal nerve as well as autonomic ganglia.
- Clinically patient present with nasal obstruction, rhinorrhea, hyposmia, epistaxis, facial pain, proptosis, epiphora, visual problem, and cranial nerve palsies.
- Bony erosion is uncommon but when present may be due to pressure necrosis from the gradually enlarging mass.
- Differential diagnosis of paranasal sinus schwannoma includes glial neoplasm, schneiderian papilloma, olfactory neuroblastoma, neurofibroma, carcinoma, sarcoma, and lymphoma.
- Total surgical excision is considered the treatment of choice

- Recurrence is seldom seen following complete resection a variety of external approach have been advocated in the past including frontal craniotomy, lateral rhinotomy, craniofacial resection , Caldwell luc mid face degloving , external ethmoidectomy.

CONCLUSION

- Schwannoma are usually asymptomatic, non recurrent benign tumors and can go undetected for years.
- Clinical history and radiographic findings on MRI can be sufficient for diagnosis.
- Surgical excision is best treating modality.
- Schwannoma are non recurrent so prognosis is good.

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