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CASE REPORT

Sausage In The Throat. A Case Of Giant Antrochoanal Polyp

BHAT M*, VAIDYANATHAN V**

ABSTRACT

We report a case of giant antrochoanal polyp, an unusual presentation in an elderly male of 60 years. He came with complains of right sided nasal obstruction and watery discharge since 9 years, accompanied with difficulty in swallowing since 2 years. The antronasal mass measured 15cm in length and 6cm in diameter extended upto pyriform fossa causing dysphagia. Patient underwent endoscopic removal of the polyp. Antrochoanal polyp is common in children and young adults but rare in elderly. With advent of newer diagnostic modalities it is rare to see such fascinating presentation. This case is reported as there are not many articles in world literature of large antrochoanal polyp in the elderly population.

Key Words: Antrochoanal polyp

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Introduction

In 1691, Fredrik Ruysch, the famous Dutch anatomist, described two cases of nasal polyps arising in the Highmoro antrum . In 1891, Zuckerkandl from Graz, described the case of a polyp arising from the maxillary sinus and coming out through a wide accessory ostium . Professor Gustav Killian, from Freiburg, in his paper "The origin of Choanal polypi". published in The Lancet on July 14, 1906, was the first to describe antrochoanal polyp (ACP) giving a specificity among nasal polyposis: "Choanal polypi are usually unilateral and solitary. They have a peculiar pear-shaped form. In the thick part of the polypus, there is usually a large cystic space. This may be prolonged well into the stalk or the stalk may consist of nothing more than the thin wall of a cyst. Microscopically, these polyps differ very little from the common nasal polyps. Choanal polyps must, in fact, all be in the form of a constricted sac of which one half is in the antrum and the other in the nose and nasopharynx. Thus a maxillary part is distinguished from a naso-pharyngeal part. By means of inflation or irrigation of the antrum through the accessory ostium, a polypus is occasionally driven out of the cavity into the nose" . ACPs represent 4-6% of all nasal polyps. Nasal bilateral polyposis is a clinical condition found in ~1-4% of the Caucasian population[7]. Most common symptom is unilateral nasal obstruction. Epistaxis,

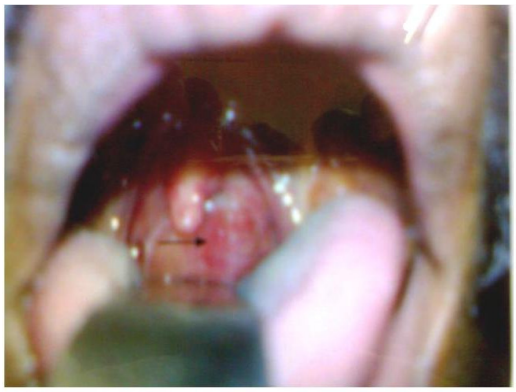
excess secretion and symptoms of chronic sinusitis can also be present. Nasal endoscopy and paranasal sinus computed tomography (CT) are used for diagnosis. The etiology of the ACP is unclear. Chronic antral disease especially chronic sinusitis and allergy are believed to be the possible etiologic factors. Importantly, allergy is reported to be present in 50-67% of the ACP cases. ACP is treated with surgical excision. Endoscopic sinus surgery (ESS) presents a reliable and effective treatment [6] .

Case Report

An elderly male of 60 years presented to the Otorhinolaryngology out patient department (ENT OPD) of Father Muller Medical College, Mangalore, Karnataka with complaints of right sided nasal obstruction and watery discharge since 9 years. He also complained of decreased sense of smell, change of voice, mouth breathing, snoring, foreign body sensation in throat, occasional headaches and difficulty in swallowing for the past 2 years.

On anterior rhinoscopic examination, a pale polypoidal mass was seen in the right nasal cavity which was insensitive and did not bleed on touch. On examination of throat, a pinkish cylindrical mass was seen hanging from nasopharynx occupying most of oropharynx and going down to right pyriform fossa [Table/Fig 1] . The indirect laryngoscopic examination view was obscured by the mass, only anterior 1/3rd of vocal cord could be seen. Lower end of mass could not be made out. Neck and ear examination were normal. On diagnostic nasal endoscopy a solitary polyp was seen coming from right middle meatus going posteriorly towards right posterior choana.

X ray soft tissue neck lateral view showed well defined soft tissue density lesion in the oropharynx extending to infrahyoid region till C5 vertebra [Table/Fig 2] .

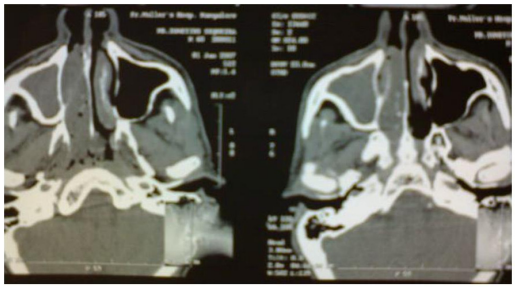


(Table/Fig 1) Mass (Arrow) Completely Occupying The Oropharynx

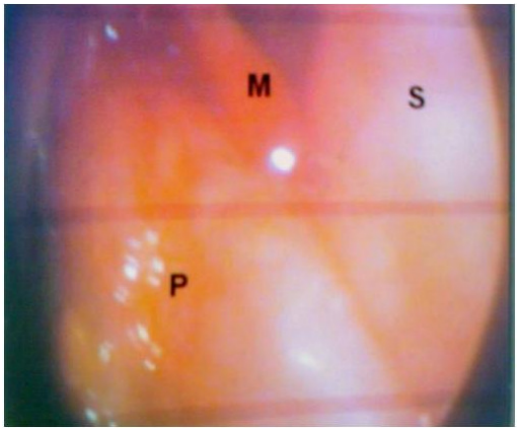
(Table/Fig 2) X Ray Soft Tissue Neck Lateral View Showing Well Defined Soft Tissue Density Lesion (Arrow)

CT scan showed well defined soft tissue density lesion arising from right maxillary sinus, extending posteriorly into nasopharynx and oropharynx, obliterating right nasal cavity and extending to infrahyoid region. There was no obvious bony destruction[Table/Fig 3]. Patient underwent Endoscopic Sinus Surgery (ESS) with extraction of the mass from the oral cavity under general anaesthesia.

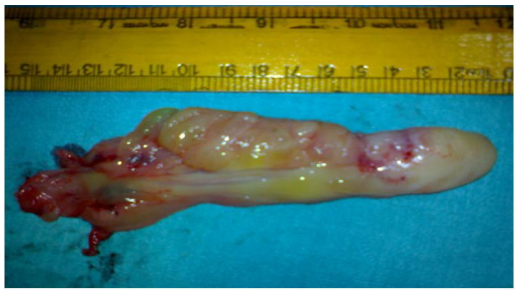
The mass measured 15cm in length and 6 cm in diameter [Table/Fig 4] , [Table/Fig 5].



(Table/Fig 3) CT Scan Showing Well Defined Soft Tissue Density Polypoidal Lesion Arising From Right Maxilla Extending Posteriorly Into Nasopharynx And Oropharynx

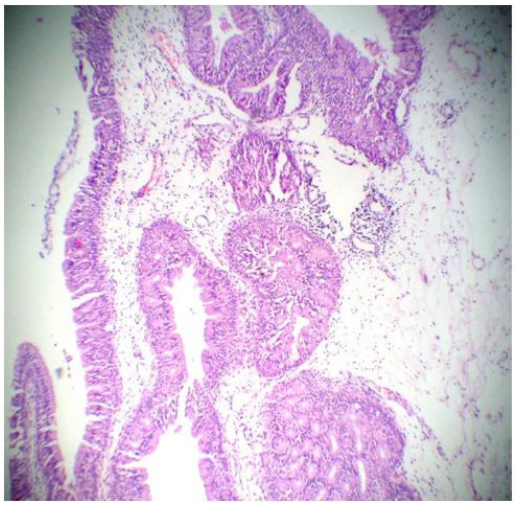


(Table/Fig 4) Endoscopic Picture Showing Polyp (M Middle Turbinate, P Polyp, S Septum)



(Table/Fig 5) Specimen

Histopathology showed pseudostratified ciliated epithelium with squamous and glandular metaplasia. Underlying stroma was edematous and showed myxoid change, few inflammatory cells and blood vessels were seen suggestive of antrochoanal polyp [Table/Fig 6].



(Table/Fig 6) Histopathology

Discussion

Antrochoanal polyps are benign soft tissue lesions arising from maxillary sinus, passes through sinus ostium and grows into choana and may extend into nasopharynx[2],[3],[5]. Antrochoanal polyp is almost always unilateral and occurs most commonly in children and young adult and incidence of antrochoanal polyp in an elderly population is rarely seen [1]. In our case it was seen in elderly male of 60 years. Nasal obstruction and nasal discharge are most common presenting symptoms, as seen in our case [2],[3]. In severe cases the presentation may be confusing with symptoms of epistaxis, dyspnea, dysphagia and weight loss. The definitive treatment of ACP is surgical removal. Caldwell-Luc procedure, polypectomy and ESS are performed for ACP treatment. ESS reinforced with sinoscopy is

reported to be a successful treatment modality. The cystic component of the ACP can also be removed from the maxillary sinus totally by using angled telescopes, angled forceps and microdebrider during endoscopic surgery. ESS procedure alone can be enough for total removal of either component of the ACP but if there is any doubt about total removal, suitable surgical procedure should be employed. Regardless of the type of surgery used, the most important point for surgical treatment of ACP is the total removal of all ACP components. Insufficient surgery results in recurrence. Recurrence rate is especially high if the pedicle of the ACP is not completely removed [6]. A similar presentation was reported in an elderly female patient with the polypoidal mass measuring 14 cm length and 5 cm in diameter, however in that case the mass was protruding out from mouth [4]. Upon reviewing world literature there is no article which describes the antrochoanal polyp so big (15 cm length and 6 cm in diameter) that too in an elderly person. This length of the polyp in our case could be attributed in delay in getting the medical care. The increased size and weight of the mass can cause its auto amputation thereby causing stridor which can be fatal [4].

This fascinating case is reported as there are hardly any articles in world literature with respect to not only age, but also size.

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