CASE REPORT

FOREIGN BODY NOSE MIMICKING SINONASAL DISEASE: A CASE REPORT

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ABSTRACT: INTRODUCTION: Foreign Body in Nose can present as sinonasal disease in Paediatric age group. Clinical and radiological examination may fail to reveal a foreign body. Two such cases are being reported for their rarity.

KEYWORDS: Foreign bodies, Sinonasal disease, Paediatric age group.

INTRODUCTION: Otolaryngologists often encounter foreign bodies in nose.^{1,2} The patients are either unable to express or afraid to reveal placing a foreign body in nose. The parents are often unaware of the same. Many patients present with unilateral foul smelling blood stained discharge and foreign body is diagnosed clinically. But very rarely sinonasal disease is diagnosed clinically and radiologically and a foreign body could be a per-operative finding. Two such cases are reported hereunder.

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CASE 1: A 7 year old girl presented with nasal obstruction on right side since 3 months. It was progressive in nature. No history of nasal discharge, bleeding per nose. No history of trauma. No history of fever. The girl or her parents didn't give any history of foreign body insertion.

Fig. 1: Showing endoscopy of Right nasal cavity

On anterior rhinoscopy followed by diagnostic nasal endoscopy, a grayish white polyp was seen in right nasal cavity with mucopurulent discharge around it. Origin could not be made out. Further examination was abandoned as diagnostic nasal endoscopy was being done under local anesthesia and the patient was not cooperative. A provisional diagnosis of Right nasal polyp was made.

A computerized tomography scan of the paranasal sinuses was taken. It showed a soft tissue density in the anterior part of right nasal cavity which was partly seen arising from middle meatal

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area. Right maxillary sinus had mucosal thickening. Posterior to the polyp, choana and nasopharynx were free from any disease.

Figure 2: Showing a soft tissue density in the anterior part of right nasal cavity (arrow head) and mucosal thickening in the right maxillary sinus and choana and nasopharynx free.

Fig. 2

Patient was taken up for surgery under general anaesthesia for polypectomy/ debridement of polypoidal tissue and sending the tissue for histopathological examination for confirmation of diagnosis.

On table, the polyp and few granulations were seen which were removed. Surprisingly inside of the polypoidal tissue was a foreign body, in the floor of nasal cavity alongside the middle turbinate. The foreign body was completely removed in piece meal and a big piece was pushed down from the choana into the nasopharynx and retrieved through oral cavity. Bleeding was controlled by cautery and nasal packing with cottonoids dipped in 4% xylocaine and adrenaline.

The foreign body retrieved from the nasal cavity was a swollen tamarind seed. Anterior nasal packing was done and removed after 24 hours. The patient was discharged 2nd post-operative day with oral antibiotics.

Figure 3: Showing polypoidal mass (arrow head) surrounding foreign body.

Fig. 3

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Figure 4: Showing part of foreign body removed per oral cavity (arrow head).

Fig. 4

CASE 2: A 3 year old male child was brought by parents with the complaint of right cheek swelling and right nasal block and discharge since 2 months. The right sided cheek swelling was diffuse and tender. Anterior rhinoscopy and diagnostic nasal endoscopy was not possible without general anesthesia. A computerized tomography scan of the paranasal sinuses were ordered to know about the underlying pathology.

Figure 5: CT scan of the paranasal sinuses.

Fig. 5

Computerized tomography showed a homogenous soft tissue density (? polyps/thick discharge) in the right side of nasal cavity, with haziness in a right maxillary sinus and ethmoids. Chonae and nasopharynx was free. Septum was pushed to the opposite side.

Patient was taken up for diagnostic nasal endoscopy and biopsy under general anaesthesia. On the table, endoscopy revealed polypoidal changes in the nasal mucosa with very thick tenacious

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mucopurulent discharge in right nasal cavity. The polyps were removed and the mucopurulent discharge was suctioned out. Again, there was a foreign body in the floor of posterior part of nasal cavity.

The foreign body retrieved was a rolled beedi leaf. It was removed in toto.

Bleeding was stopped using a cautery and anterior nasal packing done for 24 hours. Patient was discharged on 2nd postoperative day.

Figure 6: Showing thick mucopurulent discharge- endoscopic view 0°.

Fig. 6

Figure 7: Showing Foreign body I beedi leaf retrieved from right nasal cavity.

Fig. 7

DISCUSSION: Otolaryngologists frequently encounter nasal foreign bodies, particularly among children and mentally retarded patients. Patients presenting with foreign bodies in the nose or ear are predominantly children in the 2 to 8 age group,³ about 0.1%.⁴ Sometimes these foreign bodies in children go unnoticed due to inability of the child to explain what he/she has placed in her nose or sometimes due to neglect/ignorance of parents. These foreign bodies later take a different course of presentation, giving a hard time for the clinician to diagnosis.

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Fig. 8

Common sites of impaction of foreign bodies in the nasal cavity (IT = inferior turbinate; MT = middle turbinate; SS = sphenoid sinus; ST = superior turbinate).⁵

The foreign body itself may cause irritation to the patient; however, morbidity is primarily caused by the resulting inflammation, mucosal damage, and extension into adjacent structures.

Local inflammation from foreign bodies can result in pressure necrosis. This, in turn, can cause mucosal ulceration and erosion into blood vessels, producing epistaxis. The swelling can cause obstruction to sinus drainage and lead to a secondary sinusitis. Organic foreign bodies tend to swell and are usually more symptomatic than are inorganic foreign bodies.⁵

Long-standing intranasal foreign body have been reported to cause infections, including sinusitis, otitis media, facial cellulitis, meningitis, epiglottitis and tetanus.⁶

Usually unilateral discharge prompts primary diagnosis of a foreign body in a child but these cases are being reported as Clinical and radiological diagnosis of sinonasal disease was made and foreign body was found during surgery.

In two of our cases, there was no history of foreign body insertion in the nose and it was known only on Operating table. Even computerized tomography findings were misleading. A conclusive diagnosis of sinonasal disease was made for these cases. Here both were organic foreign bodies (tamarind seed and beedi leaf). Both tend to swell up and this resulted in mucosal inflammation and polypoidal changes with mucopurulent secretions.

CONCLUSION: In pediatric rhinosinusitis, neglected foreign body has to be considered.

Many a time history given by the child and the parents doesn't bring up the cause as foreign body. Computerized tomography scan can also be misleading.

An organic foreign body can present later or mimic sinusitis or polyposis. Though thorough excision/clearance should be planned for, foreign bodies may still surprise a surgeon.

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