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Case 1: An ossifying lesion of the temporal bone

MF Afshar A. Dewynter, K. Abdel-Galil, R. Hornigold, P.A. Tierney, M.J. Gleeson (Guy's & St Thomas' Hospitals, London)

A 49-year-old woman presented with a progressive right-sided facial palsy, that had developed over a period of three months. Her facial weakness was associated with a profound mixed hearing loss and ataxia. Ten years previously she had experienced the Tullio phenomenon for several months and had been investigated for this without any conclusion. Otoscopic examination confirmed she had an intact tympanic membrane through which a white mass could be seen behind the postero-superior segment. Computed tomography (CT) and magnetic resonance (MR) imaging revealed a destructive lesion in her mastoid region, which had the characteristics of a cholesterol granuloma.

At operation a calcified mass containing her incus and stapes was found which blocked the mastoid antrum and encased the tympanic segment of her facial nerve. A cholesterol granuloma was found posterior to this in the mastoid. A facial nerve decompression was undertaken by a trans-optic approach. Histological examination of the operative specimen confirmed the diagnosis of a meningioma. Her post-operative course was complicated by a brief CSF leak which sealed following lumbar drainage. Over the succeeding months her facial weakness steadily resolved, as did her ataxia.

Discussion: Meningiomas may infiltrate the temporal bone by direct extension from an intracranial site or arise within the temporal bone from arachnoid rests. To date there have been 79 case reports of meningiomas affecting the middle ear. Only 23 of these were considered to be primary lesions. Most of these lesions presented with hearing loss, tinnitus and/or varying degrees of facial weakness. This new case would appear to be unique as it initially presented with the Tullio phenomenon and only after a period of 10 years developed hearing loss, ataxia and facial palsy.

Case 2: Ecstasy associated with cervical emphysema and pneumomediastinum

R. Persaud, D. Roberts (Guy's & St Thomas' Hospitals, London)

A 21-year-old male presented with cervical emphysema after taking two Ecstasy tablets at a rave. Computerized tomography (CT) showed the emphysema extending around the prevertebral space, carotid arteries, oesophagus, aorta and trachea. There was no associated pneumothorax and a gastrografin swallow did not demonstrate any oesophageal leak. The condition resolved with conservative management.

Discussion: It is unlikely that the recreational drug directly caused the cervical emphysema and pneumomediastinum. However, it is conceivable that the Ecstasy-induced vigorous dancing led to rupture of marginal alveoli, allowing air to dissect along the pulmonary vascular sheath to the hilum and along the natural fascial planes to the neck. Doctors should be aware of this relatively new complication associated with Ecstasy so that at risk subjects could be managed appropriately.

Case 3: A case of olfactory neuroblastoma

J. Lim, M.J. Gleeson (Guy's & St Thomas' Hospitals, London)

A 51-year-old man presented to his local district general hospital with a one-year history of progressively worse right-sided nasal obstruction. There was no history of epistaxis or alteration of his sense of olfaction. His previous history included a bilateral intranasal polypectomy and septoplasty at the age of 42. Histological examination of the surgical specimen from his intranasal polypectomy revealed simple mucosal polyps.

The histological appearance of an endoscopic biopsy of the right nasal mass was consistent with an olfactory neuroblastoma. CT and MRI scanning revealed a 2 cm tumour lying anterior to the right superior turbinate, with no extension through the cribriform plate. PET and MIBG scanning did not reveal any evidence of cervical metastasis. The patient underwent an anterior craniofacial resection of his tumour via an extended lateral rhinotomy approach, and an en-bloc resection of the tumour and the right cribriform plate was achieved. The left half of the cribriform plate and olfactory mucosa was spared, and post-operatively the patient has some preservation of his sense of olfaction. The patient made an uneventful post-operative recovery, and is due to receive a course of post-operative radiotherapy.

Case 4: A case of bilateral vocal cord palsy

N. Saravanappa, M. Ward, M.L. Harries (The Royal Sussex County Hospital, Brighton)

A 63-year-old lady was referred to the voice clinic with a four-month history of shortness of breath and a weak voice. She attributed the onset of her symptoms to cervical spine surgery four months previously. Her relevant past history included subtotal thyroidectomy in 1977 for multinodular goitre and in 1993, she had a left mastectomy for ductal carcinoma of the breast, followed by radiotherapy to the breast and mediastinum. Six years later, she presented with cervical spine metastases for which radiotherapy to the neck was given. She later developed collapse of the C4/C5 vertebrae and anterior stabilization of the cervical spine with bone grafting was performed in December 1999.

Rigid endoscopic examination of the larynx revealed an immobile right vocal fold, positioned 1 mm from the midline. The left vocal fold was seen at the same level, in the paramedian position (2 mm from the midline) with no abduction. The relevant aetiological factors in this patient's history include the operation on her cervical spine, radiotherapy to the mediastinum, mediastinal secondaries, prolonged endotracheal intubation and previous subtotal thyroidectomy. The exact nature of each vocal fold immobility is difficult to ascertain.

Discussion: Treatment of bilateral immobile vocal folds is difficult, as one has to strike a balance between good voice, laryngeal competence and an adequate airway. In our case, the patient's need for a good quality of voice was of paramount importance as her husband is partially deaf and communication is a problem. She has poor mobility due to her spinal problems and her exercise tolerance is not limited by her decreased airway. During the discussion various treatment options such as continued regular observation, collagen injection to the vocal folds, tracheostomy with a speaking valve, vocal fold lateralization and laser arytenoidectomy were discussed. It was unanimously decided that the patient be given speech therapy to strengthen the left vocal fold as there was a slight movement of the left vocal fold and to consider laser arytenoidectomy at a later stage. As her prognosis for extensive metastatic carcinoma of the breast is poor, a more conservative approach with optimization of her quality of life was decided as most appropriate.

Case 5: A rare case of an undifferentiated intranasal carcinoma

R. Persaud,, F. Vaz, M. Gleeson (Guy's & St Thomas' Hospitals, London)

A 29-year-old woman presented to her local hospital with a 10-week history of nasal congestion, blood stained nasal discharge, anosmia and pain over the right maxillary and ethmoidal sinuses. On examination there was a friable mass in the right posterior nasal cavity. There was no associated ophthalmoplegia or palpable masses in the neck. MR imaging of the face revealed a large soft tissue mass occupying the upper nasal cavity on both sides of the midline with extensions into the frontal lobes of the brain and the right orbit resulting in bowing of the medial rectus muscle. Histological examination of multiple biopsies of the mass showed a poorly differentiated carcinoma, which was immuno-positive for CD56 and cytokeratins and immuno-negative for S100 and CD30. The microscopic appearance of the tumour was not consistent with an olfactory neuroblastoma. The patient was referred for radiotherapy and chemotherapy, as the tumour was inoperable.

Discussion: This case serves to remind us that a highly aggressive malignant tumour can occur in a younger person and therefore should be considered in the differential diagnosis of an intranasal lesion.

Case 6: Prolonged use of ciprofloxacin in the management of malignant otitis externa

R.G. Kanegaonkar, F. Vaz, E. Chevretton (Guy's & St Thomas' Hospitals, London)

Malignant otitis externa, with subsequent facial nerve palsy, in a 60-year-old insulin dependent diabetic woman was presented. An unusual clinical finding was that of substantial ipsilateral facial swelling. She underwent urgent left radical mastoidectomy at which inferior and posterior canal wall erosion was noted. Substantial granulation tissue within the middle-ear cavity and mastoid air cells was removed. Post-operatively, her facial nerve palsy persisted, as did her left-sided facial swelling. MR imaging demonstrated a left infratemporal fossa mass confluent with that granulation tissue excised. Due to her general ill health and psychiatric symptoms she was managed conservatively with a prolonged course (>three months) of oral ciprofloxacin. Subsequent MRI showed significant improvement, with almost complete resolution of this mass. Continued use or oral ciprofloxacin resulted in complete resolution of her left-sided facial swelling and significant improvement in facial nerve function.

Case 7: A malignant schwannoma of the nasal cavity and sinuses with metastasis to the liver

R. Chopra, E. George, G. Warrington (Crawley Hospital)

A 66-year-old healthy male presented to the ENT outpatients with a one-year history of left sided nasal obstruction, foul smelling nasal discharge, intermittent epistaxis and low backache. Examination revealed a bulging left sided external nasal pyramid and a red, fleshy mass at the left nasal vestibule, besides this there was a single soft, mobile cervical lymph node on the contralateral side of the neck and a firm non-tender hepatomegaly and pitting pedal oedema. CT scan of the paranasal sinuses revealed a homogenous opacification of the entire nasal cavity and sinuses on the left side. There was no evidence of bony destruction or spread beyond the sinuses. An ultrasonography of the abdomen revealed an enlarged liver and suggestion of diffuse infiltration. Blood biochemistry showed deranged liver function tests. Histology from the nasal biopsy showed an anaplastic tumour with the presence of Antoni cells, Verocay bodies and was positive for S100, a probable diagnosis of malignant schwannoma was made. A liver biopsy revealed similar morphology suggesting metastatic disease. Following the nasal biopsy the patient became progressively jaundiced and expired two weeks later from acute liver failure.

Case 8: A laryngocele presenting with nocturnal choking

R.D. Marx, S.T. Baer (Conquest Hospital, St Leonards-on-Sea)

We describe a case of a 55-year-old man who presented with a two-year history of intermittent episodes of nocturnal choking and occasional globus sensation. He is a heavy smoker, registered disabled for chronic obstructive airways disease and gives a history of tuberculosis and repair of a cleft lip in childhood. Prior to presentation his sleep disturbance was investigated and polysomnography excluded obstructive sleep apnoea. A recent radiograph suggested a right-sided laryngocele. After confirming the diagnosis with a CT scan and exclusion of a laryngeal malignancy with microlaryngoscopy, excision of an external laryngocele was performed, which resulted in complete relief of his symptoms.

Discussion: Laryngoceles have a UK incidence of 1 in 2.5 million and are most common in 50 to 60 year old Caucasian males. Eightly-five per cent are unilateral and the external type can be associated with laryngeal malignancy. Nocturnal choking is an uncommon presenting feature. The aetiology of laryngoceles and differential diagnoses of air filled spaces in the neck (gas gangrene and cervical emphysema) are discussed.

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