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Case report

Recurrent rare nasal tumour excised via external rhinoplasty approach

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Abstract

A 23-year-old girl presented to the outpatient clinic complaining of a painless slow growing lump on her nose for several months. She had a similar lump there which was operated one year ago. There was a well-defined, firm lump over the lateral nasal wall.Ultrasound scan confirm it's a subcutaneous lump without deep extension. Excision was done via open rhinoplasty approachand the histology report came as a giant cell tumour of soft tissue.

Keywords: Giant Cell Tumor, Rhinoplasty

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Introduction

Giant cell tumour of soft tissue is a rare clinical entity. We present a case report of a young lady who presented with a recurrence of a nasal soft tissue giant cell tumour and underwent excision via open rhinoplasty approach which promised a better approach for complete excision of the tumour.

Case report

A 23-year-oldhealthy lady presented to the clinic with a slow growing painless lump on the left lateral wall of the nose for six months. There were no other nasal symptoms such as nasal obstruction,bleeding, numbness or excessive tearing. She had a similar lump at the same place which was excised intranasally one year ago. She did not have any medical comorbidities.

The lump was a well-defined firm mass over the upper lateral cartilage of the left lateral wall of the nose. Rigid nasal endoscopy revealed normal nasal cavity and post nasal space. The rest of the medical examination including the neckwereunremarkable. There were no similar lumps noted anywhere else.

Ultrasound scan of the face noted a subcutaneous well defined soft tissue mass without attaching to the cartilage. Surgical excision was planned.

Informed written consent was taken for an open exploration.

Patient was given general anaesthesia with an orotracheal tube was fixed in themidline. A throat pack was inserted. Head end of the table was raised to 30 degrees. Nasal decongestion was achieved with 1;10,000 adrenaline soaked ribbon gauze andgently infiltrating 1;80 000 adrenaline and 2 % lignocaine along the incision after marking which consisted of an inverted V shaped transcollumella ,medial marginal columella , domal and ala crural. Incision was deepened taking extreme care near the soft triangle area. The skin envelope was raised by blunt and sharp dissections along the sub-SMAS plane (superficial muscular aponeurotic system) until the lump was reached. Then the lump was excised completely. Skin wound closed with 6/0 polyprophylline and 4/0 monoglycolic. Thin adhesive tapes applied over the nasal pyramid.Nose was packed with ribbon gauze soaked with hydrocortisone & tetracycline ointment which were removed on following day. Sutures were removed one week after the surgery. No adverse cosmetic outcome noted post operatively.

Histological diagnosis was a giant cell tumour of soft tissue. She remains free of tumour recurrence for past two years.

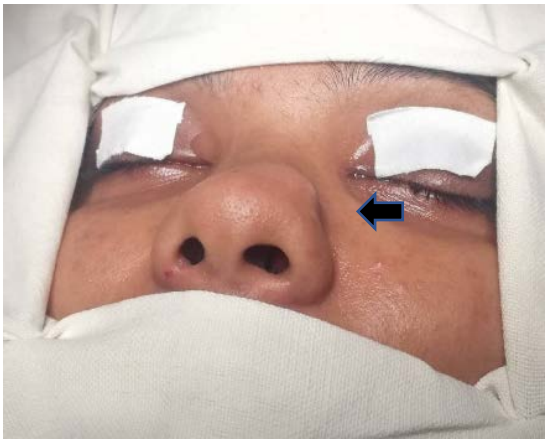

Fig.1- Pre operative appearance (Arrow denotes the lump)

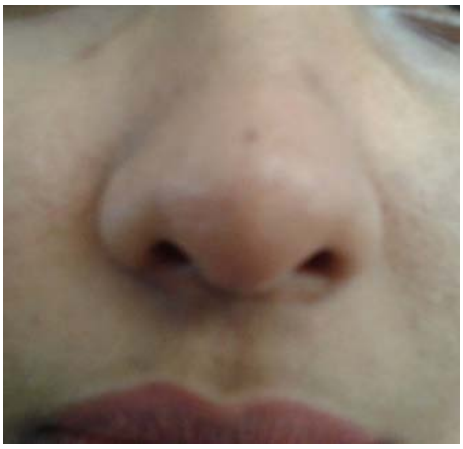

Fig.2 - appearance of the nose one year after surgery.

Discussion

Giant cell tumourof soft tissue is rare and have low malignant potential. Exact incidence is not evident[2].It exhibits high recurrence rate (6 – 10 %)[2]. This is the soft tissue counterpart of giant cell tumour of bone. It was first described by Salm and Sissons in 1972. Almost 80 % of giant cell soft tissue tumours are seen in extremities[5]. Head and neck giant cell tumours are rare accounting only 7 % [1]. It has been reported in nasal cavity,lips, parotid, pre-auricular, submandibular area and ear. Some reports nasal GCT- ST can present as pigmented ulcerated mass although our patient has a non-tender mass with normal skin overlying it.

Recommended treatment is complete excision and regular follow up to detect recurrence and rare occurrence of distant metastasisespecially to lungs.

Surgical approaches available for patients were

1. Excision via an incision along the nasomaxillary groove
2. Intranasal excision
3. Open rhinoplasty approach

As endoscopy assisted intranasal approach via intercartillaginous incision had been tried earlier we expected significant amount of fibrosis and difficulty in reaching the lateral and superior boarder of the tumour. Excision of it via an external incision leaves an obvious scar which was not accepted by the patient. Therefore, we adopted an external rhinoplasty approach, which was done carefully not to injure the cartilage framework. It resulted only a tiny scar on the columella. As she remains free of recurrence for subsequent two years, we hope this approach helped us with achieving complete excision of the tumour.

Conclusion

For dissection of nasal tumours with the potential to become malignant, open rhinoplasty approach is likely a better option than the others listed above. This has been proven in the literature [3,4].

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