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Online Only Abstract Selection

Proceedings of the 130th Semon Club, Otolaryngology Department, Guy's and St Thomas' NHS Foundation Trust, London, UK, 18 November 2005

Chairman: Miss E Chevretton, Consultant ENT Surgeon, Guy's and St Thomas' NHS Foundation Trust, London
Pathologists: Professor L Michaels, University College London, and Dr A Sandison, University College London
Radiologist: Dr S Connor, Consultant Neuroradiologist, Guy's and St Thomas' NHS Foundation Trust, London
Secretary: Mr M Black, Specialist Registrar, Guy's and St Thomas' NHS Foundation Trust, London
A prize was awarded for the best presentation of the meeting

Otology and skull base session

Chairman: Professor M Gleeson

Progressive second side ear disease: a quandry in management

R J MacFarlane, D Golding-Wood
From the Princess Royal Hospital, Farnborough, Kent, UK

Case history

A 64-year-old lady with type two diabetes presented in October 2003 with a mixed, right-sided hearing loss, a grade five right facial nerve palsy, and a mass within the right ear canal. Inflammatory markers were raised. Imaging and biopsy excluded malignancy and showed widespread granulations, prompting investigation for tuberculosis and other chronic inflammatory conditions, with negative results.

Following revision mastoidectomy and several courses of antibiotics, a trial of anti-tuberculous therapy was offered but refused. A steroid trial was resisted due to the risk of exacerbating a tuberculous process and also poor glycaemic control. Eighteen months after presentation, a similar process developed on the left, which continued despite surgery and repeated courses of antibiotics.

Discussion

Tuberculous otitis media is often histologically and radiologically non-specific. Professor Michaels demonstrated chronic inflammatory changes but no areas of necrosis or granulomata in the biopsy material presented. There was, however, evidence of osteomyelitis on computed tomography, noted by Dr Connor. A bone biopsy and sustained intravenous antibiotics were advocated by Professor Gleeson, on the basis that an infectious process, compounded by poorly controlled diabetes, was likely.

An unusual tumour of the temporal bone

R Hornigold, L Pitkin, M J Gleeson
From the Guy's and St Thomas' NHS Foundation Trust, London, UK

Case history

A 55-year-old man presented with a six month history of right-sided, non-pulsatile tinnitus and loss of hearing. The only abnormality on clinical examination was a right middle-ear effusion associated with a right mixed hearing loss on audiometry.

A magnetic resonance imaging scan revealed a right-sided temporal bone lesion, highly suspicious of a secondary deposit. Subsequently, the patient underwent comprehensive screening for a primary tumour, which revealed no abnormality. On further review, the images were thought to be characteristic of a giant cell tumour of the temporal bone and the patient was offered surgical excision. Histological analysis of the surgical specimen confirmed a giant cell tumour.

Discussion

Giant cell tumours are rare, accounting for only 5 per cent of primary bone tumours. They are classified as benign lesions but commonly recur. They most commonly occur in long bones, and treatment is usually in the form of surgical excision, with post-operative radiotherapy if excision is incomplete to prevent local recurrence.

This is the fourteenth reported case of a giant cell tumour of the temporal bone. It was originally thought to represent a secondary lesion; however, specialist neuro-radiological assessment revealed an eminently treatable lesion. We therefore recommend that the imaging of patients with temporal bone lesions be reviewed by neuro-radiologists, as in this case.

Who nose?

E Lunderskov, M Papesch
From the Whipps Cross Hospital, London, UK

Case history

A 33-year-old man presented with a severe saddle nose deformity, following spontaneous inflammation of the nose. Inflammatory markers were elevated, but tests for antinuclear antigen (ANA), rheumatoid factor (RF) and antineutrophil cytoplasmic antibody (ANCA) were negative. Eighteen months later, the patient represented with sudden sensorineural hearing loss. Full investigations were non-diagnostic.

Six months later, the patient developed three cutaneous lesions on his legs. Biopsies of these revealed a low grade leucocytoclastic vasculitis (vasculitic hypersensitivity) affecting the superficial and deep vessels. The most likely diagnosis was relapsing polychondritis, and the patient was placed on long term prophylactic methotrexate.

Discussion

An autoimmune aetiology is likely in a patient presenting with saddle nose deformity and sudden onset hearing loss. Possible diagnoses include Wegener's granulomatosis, Cogan's syndrome or relapsing polychondritis. Tests should include: full blood count, erythrocyte sedimentation rate, c-reactive protein, ANA, ANCA, RF, syphilis

serology, anti-68-kDa (inner ear) antibodies, and biopsy of active mucosal or skin disease.

Reconstructive septorhinoplasty could be undertaken when the patient is in remission and weaned off steroids. If autoimmune inner-ear disease is suspected, the patient should commence prednisolone therapy for at least four weeks. There is no evidence for the benefit of methotrexate in the acute phase, but some evidence suggests long term benefit in the prevention of further disease progression.

Believe me doctor, it's not my eczema!

H Khan, O Hilmy, N Patel
From the Royal National Throat, Nose and Ear Hospital, London, UK

Case history

A 34-year-old man presented over a period of 10 years to his general practitioner (GP) complaining of a sense of fullness in the right ear, with associated deafness and otalgia. His GP diagnosed eczematous otitis externa. The patient attended the urgent referral clinic and was found to have keratinous debris filling the ear canal. He underwent a computed tomography (CT) scan; however, before review, he presented as an emergency with a facial palsy. Mastoid exploration revealed an extensive cholesteatoma with extensive bony destruction.

Discussion

Congenital cholesteatoma, in the early stages of growth, exhibits few symptoms due to the presence of an intact tympanic membrane, often making early diagnosis difficult. Unlike acquired cholesteatoma, there is no discharge from the ear in the early stages.

There is a need for a high index of suspicion and awareness of the potential complications of this uncommonly seen condition, in a patient with few other symptoms except persistent otalgia and ear fullness. Early diagnosis followed by early surgical intervention is ideal. Definitive surgery should be considered, such as the excision of the petrous temporal bone, to avoid problems of recollection of epithelium and mycotic infection. Follow up includes serial CT scans.

Steatocystoma multiplex

J Thong, I Friedrichs, A Hinton
From the St Georges' Hospital, London, UK

Case history

A 28-year-old man presented to the ENT clinic with a long history of 'lumps' in and around both ears, associated with recurrent infections. He had previously had multiple excisions of similar lesions in France. On examination, the lesions were cystic and flesh-coloured. There were three lesions on the right: one in the preauricular region (measuring 8×8 mm), one in the ear lobe (measuring 3×3 mm) and one in the post-auricular region (measuring 3×3 mm). On the left, there was another lesion in the earlobe, measuring 3×3 mm.

The lesions were presumed to represent recurrently infected sebaceous cysts and were subsequently excised under local anaesthesia. Histopathology results revealed the lesions to be steatocystomata.

Discussion

Steatocystoma exists in two forms: simplex (if solitary and non-inheritable) and multiplex (if multiple). Steatocystoma multiplex is a rare, autosomal dominant disorder of the pilosebaceous unit. Patients present with increasing numbers of widespread, yellow to flesh coloured, cystic lesions which can become inflamed and cause scarring.

This is a benign but lifelong condition with significant psychosocial implications. Surgery may not be feasible when lesions are widespread. Other treatment options advocated include CO_2 laser therapy, cryotherapy, aspiration and, medically, oral tetracycline and retinoids.

Paediatric session

Chairman: Mr A Fitzgerald-O'Connor

The dilemma of treating hoarseness in patient with epidermolysis bullosa

H K Khan, O Hilmy, J Rubin
From the Royal National Throat, Nose and Ear Hospital, London, UK

Case report

We report a case of a 10-year-old boy with a history of severe hoarseness for two years. During that period, he underwent speech therapy without significant improvement. The past medical history was significant for epidermolysis bullosa simplex.

Microlaryngoscopy was performed due to hoarseness severity. It revealed bilateral vocal fold nodules, which were minimally excised in the superficial layer of Reinke's space. Histology showed areas of dyskeratosis within the epidermis, suggestive, but not confirmatory, of epidermolysis bullosa. Post-operatively, the patient healed without synechiae formation and continued to receive speech therapy. On follow up, he remained symptomatic but to a lesser extent. Recent stroboscopic examination showed bilateral vocal fold oedema.

Discussion

There are only a few case reports of epidermolysis bullosa affecting the larynx. Epidermolysis bullosa is a group of inherited bullous disorders characterized by blister formation in response to mechanical trauma. In such patients, surgical intervention should be kept to a minimum as it may result in exacerbation.

Further laryngeal biopsy for lesion confirmation is controversial due to potential worsening of hoarseness, the bulk of opinion being against it. Rather, annual stroboscopic assessment is felt more appropriate, with further microsurgery reserved for marked deterioration of voice unresponsive to other measures.

A rare cause of cervical lymphadenopathy in a child

J Wasson, A Rachmanidou
From the University Hospital Lewisham, London, UK

Case history

A 15-year-old boy presented to ENT with a six month history of a right-sided neck lump. The patient was otherwise asymptomatic, with no past medical history. Neck examination revealed a 3 cm, mobile, non-tender, right-sided, level II neck mass. The ENT examination was normal. Blood tests showed a hypergamma-globulinaemia and raised lactate dehydrogenase concentration.

An ultrasound-guided fine needle aspirate did not rule out malignancy, and an excision biopsy was performed. Histology was consistent with Castleman's disease (hyaline vascular type). In light of the diagnosis, an abdominal ultrasound was performed which showed no hepatosplenomegaly, and the patient was referred to haematology,

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where localized Castleman's disease was confirmed, ruling out multicentric disease.

Discussion

Castleman's disease is a rare disorder of lymph node hyperplasia. It is histologically divided into hyaline vascular and plasma cell types. The hyaline vascular type is associated with benign localized disease, curative with surgical excision. The plasma cell type is associated with aggressive multicentric disease and carries a poor prognosis. This case highlights the importance of excluding multicentric disease with a histological diagnosis of Castleman's disease.

Cervico-thoracic teratoma masquerading as lymphatic malformation

M F Bhutta, H Y Ching, B E J Hartley
From the Great Ormond Street Hospital, London, UK
Winner of the prize for best presentation of the meeting.

Case history

A case is presented of a nine-month-old male infant who presented acutely with stridor from an anterior neck and mediastinal mass compressing the trachea. Radiological assessment by ultrasound, magnetic resonance imaging and computed tomography suggested the nature of the mass to be a cervical and anterior mediastinum macrocystic lymphatic malformation (cystic hygroma). The patient was successfully treated by surgical excision of the lesion.

The excised specimen was revealed to be a mature teratoma composed of a large cyst surrounded by neuroglial tissue and with a variety of epithelial types forming the cyst wall.

Discussion

Recent literature has suggested the use of sclerosants as first line therapy for macrocystic lymphatic malformations when the airway is not compromised. The inability to distinguish between lymphatic malformation and teratoma on multi-imaging modalities, as reported here, leads to the risk of mismanaging these lesions, with the potential for continued growth of the lesion and, if malignant, metastasis or death. We question the safety of planning treatment of lymphatic malformations based upon radiological imaging in the absence of histopathological confirmation.

It was suggested that such a clinical presentation of teratoma was rare, but it was conceded that the radiological imaging of this lesion was ambivalent. The panel were of the opinion that, when there was any doubt, histological confirmation by biopsy should be undertaken.

Eustachian tube hairy polyp presenting with neonatal respiratory distress

N Agrawal, L Pitkin, G Morrison
From the Guy's and St Thomas' NHS Foundation Trust, London, UK

Case history

A three-week, term neonate presented with cyanosis. He was brought to his local emergency department and resuscitated with oxygen. Investigations, including urinalysis, lumbar puncture, chest X-ray and cranial ultrasound (to exclude periventricular leukomalacia), were normal. Repeated desaturations meant the neonate was intubated and ventilated and transferred to the regional paediatric intensive care unit. Further investigations, including computed tomography of the head, toxicology, metabolic screening and echocardiography, were normal. The neonate failed trials of extubation.

An ENT examination revealed a fleshy, white mass arising from behind the uvula. A magnetic resonance imaging (MRI) scan demonstrated the extent of the lesion and excluded intracranial extension. At surgery, a combined transoral and nasendoscopic approach was used to excise the lesion, which originated from the left eustachian tube. Histology revealed a hairy polyp. The child made an uneventful recovery.

Discussion

This case highlights the importance of a thorough ENT examination, including flexible nasendoscopy, in the assessment of neonatal respiratory distress. Hairy polyps of the eustachian tube are extremely rare dermoid lesions originating from two germinal layers, ectoderm and mesoderm. Pre-operative imaging with MRI is crucial to exclude any extracranial extension of neural tissue. These lesions are best managed with a combined transoral and nasendoscopic approach.

A cystic cause of stridor in a child

J Wasson, S P A Blaney, R Simo
From the Guy's and St Thomas' NHS Foundation Trust, London, UK

Case history

A 19-month-old boy presented with a four month history of biphasic stridor, a cystic, left-sided neck swelling and failure to thrive. Examination revealed a fluctuant swelling arising deep to the sternomastoid and bulging into the anterior triangle, and an ultrasound scan confirmed a fluid-filled cyst. Intra-operative microlaryngoscopy revealed a left piriform fossa cyst, causing the epiglottis and larynx to deviate to the right.

The cyst was excised through a left transverse cervical incision. Its anatomical course commenced in the rostral aspect of the left piriform fossa, pierced the thyrohyoid membrane, passed rostral to the superior laryngeal nerve and inferior to the hypoglossal nerve before terminating lateral to the thyroid. A post-operative microlaryngoscopy revealed centralization of both epiglottis and larynx, and stridor resolved. Histology revealed a squamous epithelium lined cyst. Both anatomical course and histology were suggestive of a third branchial cleft cyst, a rare occurence.

Discussion

Although both the third and the fourth branchial cysts originate from the piriform fossa, it is their anatomical course, particularly their relation to the superior laryngeal nerve, that differentiates one from the other.

Head and neck session

Chairman: Mr J-P Jeannon

Clear cell carcinoma of the tongue base with a papillary thyroid carcinoma

N Mehta, R Simo, S Odell
From the Guy's and St Thomas' NHS Foundation Trust, London, UK

Case history

A 48-year-old woman presented with a two month history of a hard mass in the left tongue base, associated with altered sensation. Incidentally, an asymptomatic left thyroid gland nodule was palpated during clinical examination. Biopsy of the tongue mass showed clear cell carcinoma on histology, suspected to be a primary at this site,

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derived from salivary gland tissue. Fine needle aspiration of the thyroid mass revealed papillary carcinoma with no clear cells.

The patient was treated with transhyoid excision of her lingual tumour followed by modified neck dissection. The papillary thyroid carcinoma was treated by a total thyroidectomy with level VI node clearance, followed by radioiodide ablation and radical radiotherapy.

Discussion

Clear cell tumours of the oral cavity constitute a heterogenous group of lesions which are further defined by their structural aetiology. There are some rare, unclassifiable clear cell tumours which are known as clear cell carcinoma (not otherwise specified). The appearance of a second head and neck tumour in a patient with clear cell carcinoma raises several interesting questions about the aetiology, chronology and management of the two tumours.

Aggressive fibromatosis diagnosed as peritonsillar abscess

E Kiverniti, A Singh, P Clarke
From the Royal Marsden Hospital, London, UK

Case history

A 23-year-old woman presented to her local hospital with a two month history of dysphagia, odynophagia and significant loss of weight. On examination, she had a smooth, right-sided swelling diagnosed as a quinsy. She presented to the Royal Marsden Hospital with the same swelling, which was occupying the right palate and extending to the lateral pharyngeal wall and down to the epiglottis. This time, she underwent examination of her laryngopharynx under anaesthetic, including biopsy.

Histology reported stellate and spindled cells arranged in haphazard bundles with plump, oval, vesicular nuclei with occasional mitoses, features suggesting aggressive fibromatosis, confirmed by Professor Michaels. The tumour was excised via a mandibular split with reconstruction.

Discussion

Aggressive fibromatosis belongs to a group of tumours originating from the musculo-aponeurotic structures and is rare in the head and neck. It usually presents as a painless, firm mass and, although benign, behaves in a locally malignant fashion. Surgical excision is the treatment of choice but the tumour is notorious for its multiple recurrences. We illustrate the importance of following up patients with non-remitting peritonsillar abscesses.

Mr Jeannon stressed the morbidity related to surgery of similar masses and the option of choosing surgery versus radiotherapy, as the latter has been known to produce sarcomatous changes. We feel that similar cases are best managed in a multidisciplinary team setting.

Triple parotid tumour eroding into mastoid bone

M Vouros, C Aldren, S Wood
From the Wexham Park Hospital, Slough, UK

Case report

A 72-year-old man presented with an 18 year history of asymptomatic, retromandibular swelling. After repeated reviews in the USA and a benign fine needle aspiration cytology (FNAC) report, he was reassured that surgery was not necessary. In the four months prior to presentation, he noted intermittent pain in the area and accelerated swelling. A computed tomography scan revealed a suspicious mass in the right parotid gland eroding the mastoid tip.

Although the initial FNAC indicated benign pathology, the radiological imaging suggested malignancy. Whilst surgery was indicated, the failure of agreement of the two diagnostic modalities posed a dilemma regarding how radical such surgery should be. A repeat FNAC in Wexham Park Hospital showed features mainly suggestive of a pleomorphic adenoma, but with some features of adenoid cystic carcinoma.

The tumour was excised with preservation of the facial nerve. Histology of the specimen revealed clear features of an epithelial–myoepithelial and adenoid cystic carcinoma amongst pleomorphic adenoma tissue. Professor Michaels commented that this represented a hybrid tumour arising in a pre-existing pleomorphic adenoma.

Discussion

Pleomorphic adenoma is the most common neoplasm of salivary gland origin. Although malignant transformation is described in long standing lesions, it is unusual to see the features of three tumours in the same mass, one benign and two malignant.

Sinonasal teratocarcinosarcoma: a rare diagnosis

H Y Ching, N Eze, P Williamson
From the St Georges' Hospital, London, UK

Case report

We report a highly unusual case of a 48-year-old woman presenting with a sinonasal teratocarcinosarcoma (SNTCS) involving the right nasal cavity and paranasal sinuses. The clinical presentation and course, in addition to the interesting pathological and radiological features, are detailed. The patient was treated with a combination of surgical excision and post-operative radiotherapy. The surgical approach allowed radical resection of the tumour and functional reconstruction, with excellent aesthetic results.

Discussion

Sinonasal teratocarcinosarcoma is a distinctly rare, malignant neoplasm characterized by the combined histologic features of one or more epithelial elements and mesenchymal components. It is a highly malignant neoplasm that has a poor prognosis; 60 per cent of patients die within three years of diagnosis despite intensive therapy. It exhibits aggressive growth and extensive local destruction.

Due to the aggressive nature of this tumour, the need for prompt diagnosis and commencement of appropriate therapy is paramount in the management of such patients.

Parathyroid carcinoma presenting as a pathological fracture

R F Stephen, V S P Durvasula, R M Terry
From the Princess Royal University Hospital, Farnborough Common, UK

Case report

A 28-year-old woman presented with a one month history of right ankle pain and non-specific symptoms of hypercalcaemia. The clinical examination was unremarkable. Serum biochemistry revealed elevated serum calcium and parathormone (PTH) concentrations.

X-rays highlighted an expansile, lytic lesion of the distal fibula, and a bone scan suggested generalized bone disease. A magnetic resonance imaging scan showed a solid, 3.1 cm nodule in the lower pole of the left thyroid, and marked

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uptake on Sestamibi scanning confirmed parathyroid involvement. During the course of investigation, continued subcortical bone resorption of the distal fibula resulted in a pathological fracture.

A left hemithyroidectomy with selective neck dissection was performed. A completion thyroidectomy was performed in view of the histopathological report confirming both capsular and angio-invasion. Post-operative radiotherapy, oral calcium, vitamin D and thyroxin replacement therapy followed.

At six month follow up, no loco-regional recurrence was noted and serum biochemistry was normal, with radiological evidence of remineralization of the distal fibula.

Discussion

Parathyroid carcinoma accounts for 0.1 to 5 per cent of patients with primary hyperparathyroidism. Professor Michaels emphasized that capsular and angio-invasion seen on histology are suggestive of parathyroid carcinoma but not definitive histological criteria for diagnosis. A high index of suspicion is essential when a significantly elevated serum PTH is encountered.

Rhinology session

Chairman: Mr R Simo

Synchronous schwannomas of the vestibular nerve and nasal septum

N Grover, W S F Barnes, S Baer
From the Conquest Hospital, Hastings, UK

Case report

A 79-year-old woman presented with gradually progressive, right-sided hearing loss. Magnetic resonance imaging indicated a vestibular schwannoma. We also observed a small, asymptomatic, left-sided nasal mass, but no investigations were carried out for what at that time was thought to be an incidental finding. After 14 months the patient presented again, reporting the sudden appearance of a left-sided nasal swelling after straining. A firm, pinkish mass attached to the anterior septum was observed in the left nasal vestibule. This was excised under local anaesthesia. Histopathology showed a benign schwannoma.

Discussion

Nose and paranasal sinus schwannomas comprise 4 per cent of those found in the head and neck. Nasal septum involvement is very rare; only about 18 cases have been reported (as per a Medline search).

Septal schwannomas are almost always solitary; rarely, they are part of systemic neurofibromatosis II, as reported previously. As further investigations revealed, this was not so in our case – our patient had two isolated, synchronous schwannomas. Owing to this unusual presentation, Mr Simo was of the opinion that the patient should undergo genetic testing to identify any underlying mutation.

Sinonasal sarcoidosis: a management dilemma

S C L Leong, A Hope, A Toma
From the St George's Hospital and Medical School, London, UK

Case report

A 41-year-old man with a history of pulmonary sarcoidosis presented with an acute onset of left periorbital swelling with pain. On examination, there was neither ophthalmic nor neurological involvement. This admission was the fourth presentation in a 12 month period, with the first three resulting in endoscopic polypectomy and drainage of a frontal sinus pyocele.

Computed tomography scanning demonstrated a frontal sinus mucopyocele with erosion of the posterior sinus wall. The patient underwent revision ethmoidectomy and frontal sinus sinusotomy. Nasal polyps were found occluding the frontal sinus outflow tract. Post-operative recovery was unremarkable and the patient was discharged two days later. He was reviewed by the consultant rheumatologist for high-dose steroid and anti-tumour necrosis factor α (TNFα) therapy.

Discussion

Professor Michaels confirmed the histological diagnosis of sarcoidosis, although the characteristic Langhans' giant cell was absent. Sinonasal involvement occurs in less than 1 per cent of all cases of sarcoidosis. There was general consensus that these patients were difficult to manage despite aggressive medical and surgical therapy.

The panel felt that further endoscopic surgery would cause progressive scarring and result in significant long-term morbidity. The medical option should be pursued aggressively to include combination steroid, methotrexate and anti-TNFα therapy. Referral to a rheumatologist with a special interest in sarcoidosis was also recommended.

An unusual cause of unilateral nasal obstruction and epistaxis

M Lim, S M Keh, N Brookes
From the Royal Free Hospital, London, UK

Case report

An 85-year-old woman presented with a two year history of epistaxis, left rhinorrhoea, nasal obstruction, facial pain and muffled hearing. Examination revealed a polypoidal mass adherent to the left inferior turbinate, invading the postnasal space and pushing the soft palate forward. The patient had bilateral middle-ear effusions. Computed tomography revealed a soft tissue mass in the left nasal cavity, filling the left maxillary and frontal sinuses and bilateral ethmoid and sphenoid sinuses.

Histology showed nests of pleomorphic epithelioid cells with abundant cytoplasm, large nuclei and areas of focal necrosis. Immunohistochemistry was positive for synaptophysin and vimentin but negative for S-100, melan-A, HMB-45, AE1/3, Cam 5.2, CK7, CK20, CEA, alpha-FP, HAS and chromogranin A. This supported a diagnosis of paraganglioma. Due to the patient's age, extent of tumour, significant ischaemic heart disease and personal preference, she was treated palliatively with radiotherapy.

Discussion

Dr Connor felt that there was bony erosion of the cribriform plate, indicating an aggressive process. Dr Sandison agreed with the likely diagnosis of paraganglioma but raised renal cell carcinoma metastasis as a possibility and suggested that further immunohistochemistry might be useful. Paragangliomas are usually benign tumours and the mainstay of treatment is surgery. Radiotherapy controls but does not cure the disease.

An unusual bone tumour

N K Ibery, P M Patel, J H Hadley
From the Royal Surrey County Hospital, Guildford, UK

Case report

We present a 29-year-old man with a firm, bony swelling just below the right medial canthus. He had no ophthalmic

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or nasal symptoms. Clinical examination revealed a $2 \times 1 \times 0.5$ cm, non-mobile mass. Computed tomography (CT) examination was suggestive of possible primary bone tumour.

An endo-nasal biopsy was performed and the histology showed ossifying fibroma. The patient underwent localized resection of the tumour and at the time of writing was being followed up in our clinic.

Discussion

The ossifying fibroma is a type of 'fibro-osseous lesion'. It is usually seen between the second and fourth decades of life, with women being affected more often than men. Less than 5 per cent involve more than one bone, and lesions are almost exclusively found in the cranial bones. The mandible is the most common site (75 per cent in some series), followed by rarer reports of involvement of the ethmoid, frontal and sphenoid sinuses as well as the orbit, occiput and temporal bone.

Traditionally, the initial treatment of ossifying fibroma has been simple curettage, leaving more definitive resection for recurrent disease. During the discussion, it was highlighted that imaging, which included CT scanning, was not a sufficient diagnostic tool and that histopathological confirmation was required to establish the diagnosis.

Inverted papilloma associated malignancy: a case report

R Saaj, S Davis, S Habashi
From the Chase Farm Hospital, Enfield, UK

Case report

A unilateral nasal mass in a 32-year-old woman was diagnosed as inverted papilloma on biopsy, and she underwent surgery via combined a endoscopic and transantral approach. Complete macroscopic excision was achieved.

The histology confirmed inverted papilloma with no malignancy. The patient defaulted on follow up and, seven years later, presented with an extensive, moderately differentiated squamous cell carcinoma with orbital involvement on the same side. She had a large local recurrence after extensive resection and was advised palliative radiotherapy.

Discussion

The histology slides were reviewed by Professor Michaels. He disagreed with the initial histological diagnosis of only inverted papilloma and demonstrated areas of low-grade malignancy within the inverted papilloma.

The discussion that ensued concluded that the misdiagnosis was unfortunate, and the presenter concluded that thorough histological examination by an experienced pathologist is important in the diagnosis of synchronous malignancy in patients with inverted papilloma.

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