

Case of suprastructure maxillectomy: A new classification beckons?

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SUMMARY

Maxillectomy has been classified in the literature broadly as limited, subtotal and total maxillectomy. "Limited" refers to any maxillectomy which primarily removed one wall of the antrum. (ie, palate, anterior wall, medial wall) "Subtotal" refers to a maxillectomy which removed at least two walls, including the palate. "Total" refers to excision of the entire maxilla, which may include removal of the orbit and sphenoidectomy and resection of the pterygoid plates and resection of the lamina papyracea. Rarely does a maxillectomy involve removal of all walls except the hard palate. We present a case that necessitated such a procedure. Our patient had a recurrent solitary fibrous tumor of the lacrimal sac that involved the orbit and suprastructure portion of the maxilla but spared the hard palate. He underwent a right suprastructure maxillectomy with right orbital exenteration and anterolateral thigh (ALT) myocutaneous flap reconstruction. This case demonstrates that suprastructure maxillectomy is necessary in the appropriate oncologic case. This case brings to question the need for a change in nomenclature and definition of types of maxillectomy.

Acute rhinosinusitis with complications: Gold standard of imaging

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SUMMARY

Acute rhinosinusitis is defined as infection of the mucosal lining of the nasal cavity and paranasal sinuses not exceeding twelve weeks. The course of the disease is usually self limiting and resolves with conservative management. However, they are known to cause life threatening complications such as meningitis and cerebral abscess. Intracranial complications need to be detected rapidly and timely intervention saves life. This case report highlights the diagnosis dilemma and detection of intracranial complications. We report a case of a 72-year-old gentleman with underlying hypertension, diabetes mellitus and bilateral hearing impairment who were initially referred to the ophthalmology team with complaints of headache, drooping of right eyelid and malaise for three weeks. Besides that, the patient had an incomprehensible speech for 3 days. A CTA cerebral was done and it showed aggressive right orbital apex soft tissue lesion with local infiltration which includes the possibilities of direct extension of adjacent right sphenoid soft tissue lesion or secondary metastasis with a possibility of paranasal sinus aggressive soft tissue tumour. Patient was subsequently referred to us for biopsy and further management. On our examination, the patient was not orientated to time and place, unable to obey command and was restless. We managed to scope the right nasal cavity, however no mass or mucopus noted. Due to the dilemma in taking a biopsy, the case was discussed with a rhinologist and HRCT PNS were planned. However patients' GCS worsened and the patient was referred to the neurosurgery team. MRI brain and paranasal sinuses was subsequently done and it was suggestive of pansinusitis with regional inflammatory changes and multiple subdural empyema. Despite coverage with antibiotics, patient succumbed to secondary sepsis and intracranial complications. This case report highlights the dilemma in diagnosing acute rhinosinusitis with complications versus aggressive sinonasal tumour. Different imaging modalities will assist in early diagnosis and management of patients.