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A Stitch in Time Saves Nine

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The need for timely diagnosis has been stressed time and again right from the beginning of clinical postings in medicine. It's only a right diagnosis at the right time that can help in early institution of appropriate therapy which is the secret to success in management of a patient. Science has progressed leaps and bounds over years and will continue to do so. Nevertheless, the need for good clinical acumen and precise technical expertise even today remains to be the need of the hour. The only way to help our patients and society at large is by continuing in our quest to develop these skills as we move forward in the medical profession.

Here I pen down my experiences of how early diagnosis and appropriate treatment helped in the pursuit of reducing the distress and difficulties faced by patients.

Case 1: We are aware of the epidemic within the pandemic and all ENT surgeons in India have been witness to the surge in Mucormycosis cases. One such patient a 53-year-old lady presented with proptosis of the left eye which had increased over 3 days with no other nasal symptoms. There was no history of diplopia or dimness of vision. The patient had no co-morbidities and had received both vaccines against SARS-CoV-2 virus with no history of COVID-19. The Diagnostic Nasal Endoscopy (DNE) done at a clinic showed a smooth reddish mass in the middle meatus on the left side extending over the lateral wall with pus noted. An MRI nose and paranasal sinuses with orbit was done which showed altered signal intensity lesion predominantly T2 hypointense in the ethmoid sinus and frontoethmoidal recess on left side breaching the lamina papyracea and extending into medial part of left orbit involving medial rectus and superior oblique with impression of likely fungal pathology (Figure 1). This patient was referred with likely diagnosis of fungal rhinosinusitis and we admitted the patient for DNE and biopsy. The DNE done revealed a mass in the left middle meatus involving the ethmoidal bulla with extension over lateral wall. The lesion was friable and vascular with no crusting or characteristic features of fungal rhinosinusitis. The biopsy was taken and HPR revealed infiltration by malignant neoplasm consistent with Non-Hodgkin's lymphoma. IHC confirmed B cell Non-Hodgkin's lymphoma high grade. The whole body 18F-FDG PET/CT scan was done for staging and disease status evaluation. The patient was started on chemotherapy and is on follow up. A timely diagnostic nasal endoscopy with biopsy enabled appropriate diagnosis and treatment. The relevance of multidisciplinary approach is evident with the ENT surgeon, radiologist, pathologist and medical oncologist working in unison. The proficiency in DNE can definitely help early appropriate diagnosis.

Case 2: A 50-year-old lady admitted in the medicine ward with a history of focal seizures and loss of consciousness was investigated and the imaging done revealed lesion involving the sphenoid

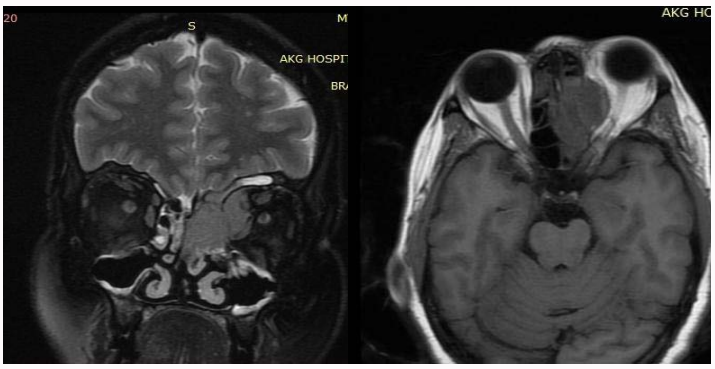

Figure 1: MRI Nose and paranasal sinuses coronal and axial cuts showing the mass in the left ethmoid and frontoethmoid regions with breach of the lamina papyraceae and extension into the orbit left abutting the medial rectus muscle.

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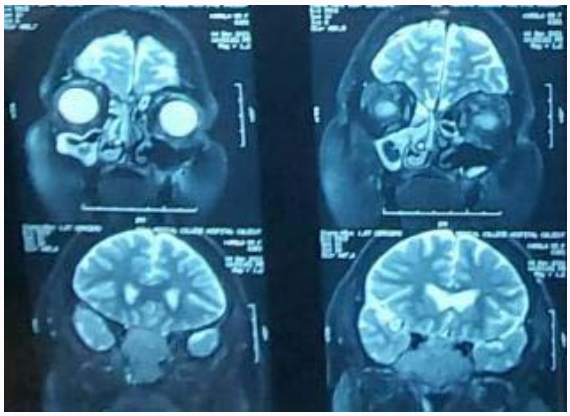

Figure 2: Coronal sections of Nose and PNS showing T2 hyperintense lesion with diffusion restriction and uniform post contrast enhancement seen involving the sphenoid sinus with lesion occupying the nasopharynx with involvement of the clivus.

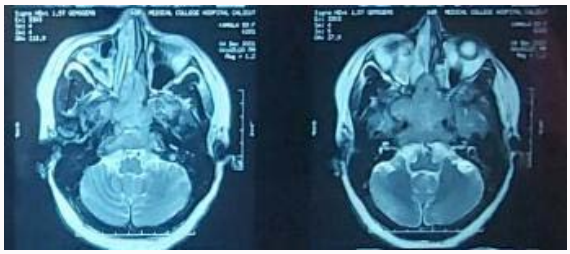

Figure 3: Axial sections confirming the extent of the lesion as in Figure 2.

sinus with involvement of the clivus and contiguous extension into bilateral cavernous sinus with encasement of proximal segment of cavernous internal carotid artery. The lesion is posteriorly abutting basilar artery and inferiorly projecting into the nasopharynx (Figure 2, 3). This patient was referred to the ENT outpatient department for evaluation and expert opinion. The patient was on Ryle's tube feed and recovering. On evaluation she had rhinolalia clausa with DNS to left. The diagnostic nasal endoscopy revealed a smooth bulging mass occupying the entire nasopharynx with obstruction of both the choana right more than left. The biopsy would require a representative sample which made it necessary to obtain a deep biopsy and multiple adequate samples taken to ensure appropriate diagnosis. The HPR was a plasmacytoma confirmed with IHC. The patient required work up to rule out multiple myeloma. In view of the diagnosis the patient was referred to medical oncologist for appropriate chemotherapy and is on follow up.

The above two cases highlight the significant role of an otorhinolaryngologist in helping make the appropriate diagnosis by meticulous timely performance of a DNE and biopsy which is crucial in initiation of appropriate treatment. DNE is a well-tolerated, relatively safe and cost-effective investigation modality which when put to right use can help early diagnosis. Nasal pretreatment and proper counseling with consent is the most important part to ensure patient tolerance. Though considered an OPD procedure, in patients requiring biopsy the extent of the lesion dictates preparedness in the event of any eventuality.

In both the above cases late diagnosis and spread of the disease are significant prognostic factors associated with a poorer treatment outcome. Therefore, uses of the diagnostic procedures to enhance the sensitivity of the clinical evaluation are desirable. We need to appreciate the need for good clinic-radiological co-relation along with histopathology in being able to make the correct diagnosis.

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