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HAMARTOMA OF THE NASAL CAVITY: A CASE REPORT AND REVIEW OF THE LITERATURE. ☆

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ABSTRACT

Abstract

The authors report the first case of nasal hamartoma observed in Kinshasa (Democratic Republic of Congo). The patient was a 12-year-old girl admitted with a tumor on the right side of the nasal pyramid that extended to the infraorbital region. The mass had recurred 3 years after initial removal and the patient was referred to our hospital. She presented with chronic rhinitis and nasal obstruction for several months. The maxillofacial CT scan suggested a benign process with no calcification lesions or signs of osteolysis. The tumor was completely removed via the paralateronasal approach and the post-operative course was straightforward. The histopathological diagnosis was that of a hamartoma. This is a rare, benign tumor consisting of a proliferation of one or more specific components of a given tissue. The majority of hamartomas are found in the lungs, kidneys and intestine, while their presence is exceptional in the ENT sphere, and especially in the nasal cavity. A correct differential diagnosis with other ENT tumours is essential because of the different therapeutic approaches.

INTRODUCTION

Hamartomas are non-neoplastic tumor lesions corresponding to malformations in the embryonic development of certain tissues and are found mainly in children. Hamartomas are common in the kidneys, lungs and intestines, but are rarely found in the ENT sphere, especially in the nasal cavity and paranasal sinuses (1). The most common site of onset in the nasal cavity is the posterior surface of the nasal septum (2). Clinical signs depend on the extent of the tumor in relation to neighboring structures, and diagnosis is not always straightforward. We report a case of a 12-year-old girl with a mass on the right lateral aspect of the nasal pyramid that had been evolving for several months and associated with homolateral nasal obstruction.

II. MATERIALS AND METHOD

I. Material

A. Study environment

This study was carried out in the ENT and anatomy and pathology departments of the University Clinics of Kinshasa.

II. Method

In this clinical case study, we used the experimental method, the observation technique and structured interviews. Questioning was used as a data collection tool.

III.RESULTS

The patient was a 12-year-old girl with right nasal obstruction and a mass in the right lateral wall of the nasal pyramid that had been present for several months, with no history of epistaxis. Her medical history was unremarkable. It was reported that the mass had been removed and recurred 3 years after the initial surgery. On physical examination, a right paralateronasal swelling was noted,

taking up the external face of the nasal pyramid, deforming the latter and extending to the right infraorbital region. On his forehead, there was a hypochromic spot approximately 3 cm in diameter.

The skin opposite the swelling bore a linear scar approximately 6 cm long, flat and parallel to the back of the nose. Otoscopy, anterior rhinoscopy and examination of the oropharynx were

unremarkable. The same was true of the ophthalmological and neurological examinations.

The maxillofacial CT scan showed a paralateronal soft tissue mass on the right, above the homolateral maxillary nasal region, extending into the right suppurative groove of the nose, measuring approximately 2.6x2x2 cm with regular contours.

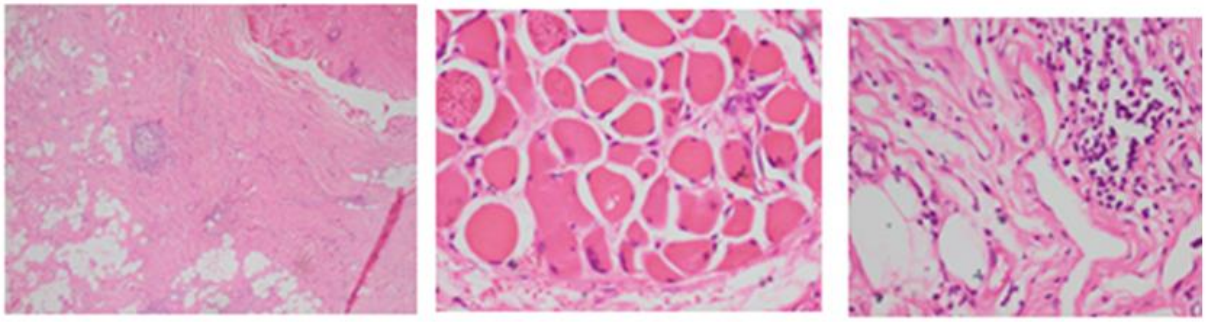
After injection of the contrast medium, a well circumscribed mass of exophytic development with no signs of calcification, erosion or bone and skin expectoration (image not shown). The surgical treatment carried out by the ENT and maxillofacial teams consisted of total removal of the tumor via the paralateronasal route under general anesthesia. The intraoperative findings were marked by the adhesion of the mass to the anterior wall of the right maxillary bone. The tissue fragment removed was yellowish-white, firm, with a smooth surface, measuring 3.1 x 1.5 x 1cm.

Histopathological analysis of the samples revealed fibrofatty tissue and striated (skeletal) muscle containing numerous nerve threads and poorly arranged histological blood vessels. In addition, there was a predominantly lymphocytic inflammatory

infiltrate of moderate intensity with a tendency to form local lymphoid nodules.

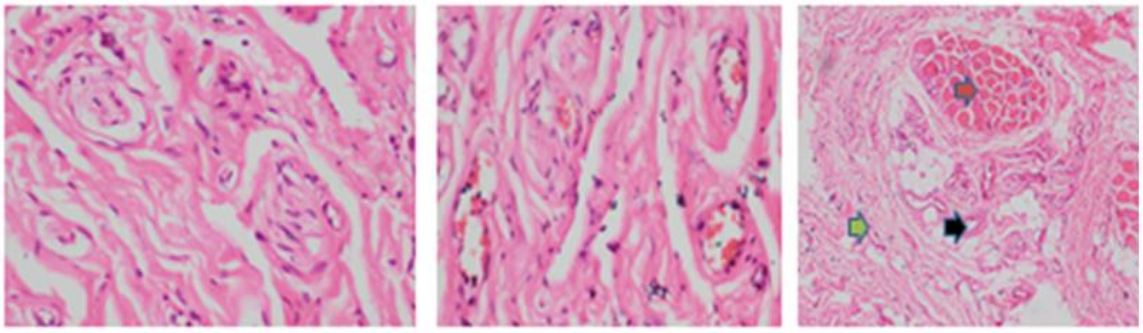
There were no signs of malignancy or inverted papilloma. The fibrous stroma enclosed poorly arranged tissue, which was histologically compatible with a Hamartoma.

Figure I: Para lateronasal hamartoma



A: HEX40 fibrofatty tissue (black arrow shows adipose tissue, blue arrow shows fibrous tissue and red shows lymphoid nodule); B: skeletal striated muscle tissue HEX400 (blue arrow) and C: shows an inflammatory lymphocytic infiltrate with a tendency to form a HEX100 lymphoid nodule (red arrow).

Figure 2 : Para lateronasal hamartoma HEX400



in A there are nerve nets (blue arrow), in B we have congestive vessels (blue arrow) and in C: a mixture of adipose tissue (blue arrow), queletal striated muscle (red arrow), fibrous tissue (green arrow) and congestive vessels (black arrow)

Source: *Images of the results of histopathological analyses carried out at the anatomopathological department of the University Clinics of Kinshasa.*

IV. DISCUSSION

Hamartomas are a non-neoplastic proliferation of mature/differentiated tissues indigenous to the specific part of the body in which they develop [3]. This benign tumour, mainly described in children, is an error in the embryonic development of certain tissues.

Most hamartomas are found in the liver [4], skin [5], lungs and pancreas [6], spleen [7], although their location in the nasal cavity is exceptional, and several hamartomas of the nasopharynx have been reported in the literature [8].

Hamartomas are classified into epithelial, mesenchymal or mixed

epithelial and mesenchymal types. Hamartoma development is insidious, ranging from a few months to 69 years [9], and symptomatology depends on its location.

This justifies a late consultation of our patient 7 years later, who presented with nasal obstruction and deviation of the nasal septum. In our case, there were no ophthalmological complications and no association with nasosinus polyposis.

Whereas C. Nagouas et al. in their series found a mean age of 58.5 years with a correlation between nasal hamartoma and nasosinus polyposis [10].

Medical imaging revealed the topography of the tumor, which was well circumscribed with no calcifications or osteolytic lesions, ruling out malignancy.

Hamartoma is considered a benign tumor, although malignant transformation is possible [11].

However, chondronmesenchymal hamartomas present invasive lesions simulating a malignant process [12]. For this reason, the definitive diagnosis of hamartoma is anatomopathological examination [13], which has revealed lesions typical of this tumor, made up of fibrofatty tissue and striated (skeletal) muscle containing numerous nerve threads and poorly arranged histological blood vessels.

Differential diagnoses must be made with other masses, in particular inverted papilloma, respiratory adenoid hamartoma, squamous papilloma and nasal polyp [14].

Hamartoma treatment is based on complete surgical removal [15] The surgical approach used in our case was paralateronasal because it offered satisfactory access for the various procedures.

V.CONCLUSION

Nasal hamartoma is a rare benign tumour. In a clinical study of a 12-year-old girl, with lesions as developed above, using the experimental method, the observation technique and structured interviews, while questioning served as an instrument of data collection, we found after examination that medical imaging offers a diagnosis of orientation, while that of certainty is based on histopathological examination.

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