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## Case Report

## Bleeding sphenoid sinus - unusual presentation for a clival metastasis



Abdul Wadood Mohammed MS DNB MNAMS, Consultant <sup>a,\*</sup>, K. Praveen, Consultant <sup>b</sup>, K.K. Amrutha, Resident <sup>b</sup>

<sup>a</sup> Department of Otolaryngology, Kims Alshifa Healthcare Pvt Ltd, India

<sup>b</sup> Department of Neurosurgery, Kims Alshifa Healthcare Pvt Ltd, India

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## ABSTRACT

**Problem:** Epistaxis is a common symptom among middle aged and old aged population especially when they suffer from hypertension or on antiplatelet therapy for coronary artery disease. When such patient present with epistaxis, it is customary to attribute their bleeding to their comorbidity. Clival tumors are extremely rare in the spectrum of skull base tumors. Metastasis into the Clivus is even rarer. Clival metastasis can occur from a variety of primaries and can sometimes occur in a setting of an occult primary. In such cases, their detection would exclusively depend on the symptoms at the clival region.

**Method:** Case report.

**Case:** We report of a middle-aged male with a known history of cardiac disease who presented with epistaxis. His epistaxis was initially attributed to the use of antiplatelet therapy. However, due to persistent symptoms radiology was done which revealed a clival lesion. A transsphenoidal biopsy was taken which came out to be metastatic adenocarcinoma.

**Conclusion:** We discuss this case due to its atypical presentation, the technique of transsphenoidal biopsy and review of the literature.

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## Introduction

Clivus is a midline skull base region just caudal to the sphenoid forming the posterior wall of sella turcica. Tumors of clivus are rare and clival Chondroma and chondrosarcoma form the major share of the list. However, together they compromise only 0.1–0.2% of the skull base tumors [1]. Metastasis to clivus is even rarer with only 47 cases reported previously in the literature [2]. Primary sites from which bone metastases occurs are breast, prostate, kidney, and thyroid. Metastatic adenocarcinoma in the clivus can occur from prostate, breast, lung or thyroid [3]. The clinical presentation of clival lesions is varied with cranial nerve involvement in the form of abducens nerve palsy being the most common presentation. There is only one reported case of such lesion presenting as epistaxis [4]. Other presenting complaints include headache and multiple cranial nerve palsies like ptosis, ophthalmoplegia, vision loss, facial pain, dysarthria etc [4]. Hence, the diagnosis of such lesion requires a high degree of suspicion. The majority of lesion present with either a primary tumor or previous history of malignancy making the

\* Corresponding author. Department of Otolaryngology, Head and Neck Surgery, Kims Alshifa Hospital Pvt Ltd, Perinthalamanna, Kerala, 679322, India.  
E-mail address: [wadood83@gmail.com](mailto:wadood83@gmail.com) (A. Wadood Mohammed).

diagnosis during the metastasis work up. However, as in our case when it presents with occult primary, the diagnosis becomes much more difficult and need much suspicion. We present this case due to the atypical clinical scenario, the dilemma we had in the diagnosis and how we proceeded to provide the patient with optimum care. We also discuss the procedure of transsphenoidal clival biopsy.

## Case report

A 61-year-old male patient presented to the outpatient department with a history of trivial epistaxis of one-month duration. He typically complained of having the bleeding in the early morning when he bends forward. He was symptomatic during the rest of the day. He was a hypertensive and had coronary artery disease for which he was on antihypertensives and antiplatelets in the form of aspirin and clopidogrel. His general and physical examination was normal. Neurological examinations were unremarkable. A diagnostic nasal endoscopy was done which showed minimal ooze from the sphenoidal recess, medial to the middle turbinate. The bleeding was thought to arise from the woodruff's plexus area which is common in hypertensives. The patient was taken for nasal endoscopy and cauterization of the bleeding under general anesthesia as he was having persistent symptoms. The patient was symptomatic for one month after which he had a recurrence of epistaxis. A contrast enhanced computerized tomography was done to look for any vascular malformation. The radiology revealed an osteolytic lesion involved the floor of the sphenoid sinus and the clivus. It showed homogenous post contrast enhancement involving the upper clivus without involving the brain and paranasal sinus [Figs. 1 and 2]. A Gadolinium-enhanced magnetic resonance imaging was done which showed intense enhancement of the lesion with hypoechoic areas suggesting necrosis [Fig. 3].

The patient was taken up for endonasal transsphenoidal clival biopsy under general anesthesia. Intraoperatively on exposure of the sphenoid ethmoidal recess, the bleeding was localized to occur from the sphenoid sinus osteum [Fig. 4A]. The superior turbinate on the right side was cauterized and resected [Fig. 4B]. A nasoseptal flap was created on the right side and the rostrum of sphenoid was exposed. The sphenoid sinus ostium was exposed on the right [Fig. 4C] and left side [Fig. 4D]. The both Ostia were widened [Fig. 5A] and rostrum of sphenoid was removed for wide exposure [Fig. 5B]. The tumor was found to erode the posterior wall and floor of the sphenoid sinus. The Tumor was bleeding to touch and had a very thin capsule [Fig. 5C]. The capsule was cauterized with bipolar diathermy and opened and punch biopsy was taken [Fig. 5D]. The defect was plugged with fat obtained from the abdominal wall and gel for and a previously harvested nasoseptal flap was repositioned over the tumor. Hemostasis was achieved and anterior nasal packing was done which was removed on the 5th day. The post-operative biopsy came as poorly differentiated adenocarcinoma [Fig. 6]. Immunohistochemistry staining for chromogranin was positive and S 100 and NSE was negative. The patient was referred to a higher center for further work up and treatment. The patient underwent a PET scan to detect the primary lesion, however no primary malignancy was detected. The final diagnosis of secondary metastasis with occult primary was made and the patient received radiation therapy. The patient was followed up for 1 year following the treatment during which he developed one episode of cerebrospinal fluid rhinorrhea which was treated by endoscopic repair. Other than that the patient remained asymptomatic except for occasional nasal discharge and crusting which was treated conservatively. The patient is planned for PET scanning in the follow up visits.

## Discussion

Clivus is an extremely rare site for tumors to metastasize. Like the spinal metastasis, metastasis to clivus is thought to be hematogenous. It can be either through the Batson plexus into the internal vertebral venous plexus system which

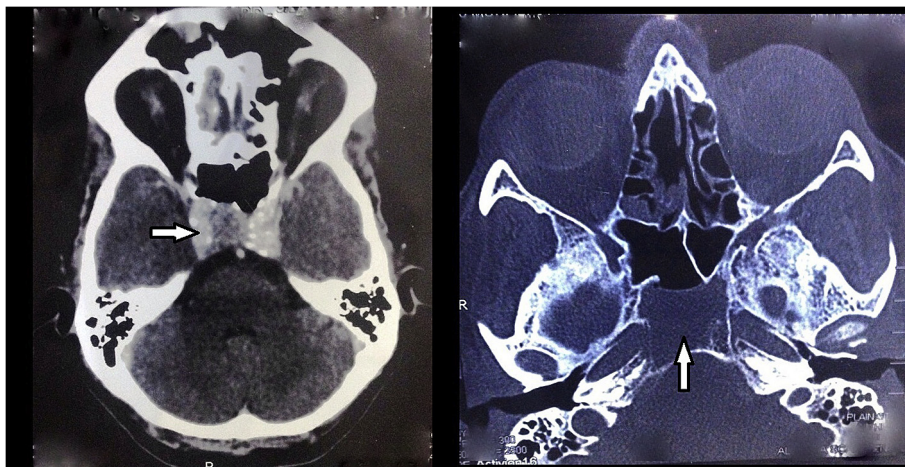


Fig. 1. Axial cuts of Computed tomography showing the lesion in the clivus (denoted by the arrow).

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