Readers' Forum: 12

Q.1 What is the current treatment of Rhinoscleroma?

A.1 As far as current treatment of Scleroma is concerned the principle is first to control the activity of disease medically. The best drug of choice is Cap. Rifampicin 450 mg daily for 2 months. I would also give low dose 5 mg B D of prednisolone for 6 months. To confirm control of infection by doing culture of specimen from lesion. When two subsequent cultures are negative it is said controlled infection/Inactive infection.

- Before starting medication it is important to do biopsy and culture to confirm the diagnosis.

- To do subsequent cultures to see activity of disease, one point important to note is the organisms KL. Rhinoscleromatis are intracellular so the biopsy specimen from lesion needs to be crushed between the slides to release the organism and then do the culture. Once the disease is medically controlled only then to go for surgical intervention which is usually called for due to fibrosis resulting in stenosis.

Principle for surgery is :

- Excision of fibrosis scar preferably with laser followed by
- Stenting or else fibrosis recurs.

So in short :

1. Confirm the diagnosis of scleroma with biopsy and culture.
2. To start patient on medical treatment with Cap. Rifampicin 450 mg. B B till the culture is negative (2 subsequent). Important point to note is to crush the biopsy specimen between two slides before culture, as the Organisms. (KL, Rhinoscleromatis) are intracellular.

3. Surgical intervention only offer the disease is medically controlled.

- Excision of fibrous scan (preferably with laser)
- Followed by stenting.

Dr. Hetal K Marfatia

Mumbai

Animal experimentation has revealed that the combination of Carbolic acid (2%) and Glycerine (4%) mixture possesses necrotising, antiscelerotic, antiseptic and vasospastic properties. Acetic acid alone is deeply necrotic and antisclerotic while Carbolic acid alone though less necrotising is antiseptic and anaesthetic in addition. Glycerine acts as a slow releasing hygroscopic vehicle. The combination thus proved to be an ideal one for painless, aseptic chemical necrosis unattended with troublesome fibrosis.

Composition : Pure carbolic acid 0.2ml., Glacial acetic acid 0.2ml., Glycerine IP 0.4ml., Aqua dist. ad. 10 ml. Autoclave the solution.

Its usage for chemical ablation of Scleroma Nose, as already reported (I,J.L.O.30(2):68-69) has proved beneficial 0.25 ml. Of the autoclaved mixture is injected at each site of the lesion for a total of 2 ml. at one sitting twice a week. Repeated local injections of this mixture for 6-10 weeks duration is supplemented by nasal dilatation and indwelling rubber tubes when necessary.

A long term follow up of these cases has convincingly proved that the nasal vestibular granulomatous lesions of Scleroma regress completely by this conservative treatment. The patency and appearance of the nares is restored to normalcy. It has been substantiated by successive histological studies.

However, deep seated nasal and faucial lesions have shown poor response. A long term, cautious follow up is essential to detect recurrences and

manage them suitably.

Dr. Kailash Rai
Jaipur

Q.2 How do you manage a case of Inverted Papilloma of Nose?

A. Lately, we are managing inverted papilloma endoscopically.

Steps :

- To confirm diagnosis by biopsy in clinically suspicious cases of inverted papilloma which classically presents as unilateral, pinkish polyps arising from middle meatus with occasional history of epistaxis.

- Limited CT Scan of PNS to see the exact extent of inverted papilloma.

- FESS is done to excise inverted papilloma with adequate widening of maxillary ostium. Extended applications of FESS does permit good clearance of inverted papilloma.

- Post operative scan is mandatory to confirm complete excision and rule out any residue.

Regular follow up is a must. If there is any recurrence then medical maxillectomy should be done.

Dr. Hetal Marfatia
Mumbai

Inverted Papilloma is a benign neoplasm originating from the schneiderian membrane of nose and paranasal sinus cavities. It has varied clinical and histological presentation involving lateral nasal wall, septum, ethmoids, maxillary and sphenoid sinuses extending to skull base and cranium. It has highest recurrence rate of 70% and has tendency to transform into carcinoma (5 to 15%).

Management :

1. A detail clinical examination of a case by F/O naso-endoscopic evaluation.
2. Evaluation of High resolution coronal CT

scan of Nose and Paranasal sinuses.

3. Clinical staging of a case as follows :

Stage I :

Lesions involving nasal cavity only. This stage is managed by intranasal removal of the papilloma by endoscopy with full clearance of the ethmoids and lateral wall. The appropriate intranasal antrostomies and if required CWL procedures should be done.

Stage II :

Lesions involving nasal cavity + Paranasal sinuses. This is managed by endoscopic nasal, sphenoethmoidal and maxillary clearance by lateral rhinotomy approach.

Stage III :

Lesions involving nasal cavity, Paranasal sinuses and skull base extensions. Mostly these lesions are due to high recurrence.

This is managed by Radical surgery involving lateral Rhinotomy + Medial Maxillectomy + Spheno-ethmoidal clearance (Enbloc dissection).

In view of high recurrence and transformation in to Transitional cell carcinoma DXT therapy of 6000 rads is advocated.

Above all prognosis is guarded and hence wait and watch policy is must.

Note : The article on this is published in ILO & HNS/Vol.49 No.1 Jan-March 1997.

Dr. K. K. Desarda
Pune

NEW QUESTIONS :

1. What is the current status of intact canal wall tympanoplasty and in which cases of CSOM you will prefer to do the same?
2. What kind of prosthesis you will prefer to replace incus in ossiculoplasty?

Kindly support your choice with your results.

Compiled by :
Vinod H Shah

'Shruti' ENT Hospital,
Opp. Sub Jail Ring Road,
Surat 395 002
Fax : 91-261-665757