

RHINOLITH : AN UNUSUAL PRESENTATION

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ABSTRACT : A case of rhinolith in a 60 years old male presenting with palatal perforation is presented alongwith a brief discussion on the pathogenesis and treatment.

Key words : Rhinolith, Palatal perforation, Oronasal fistula

INTRODUCTION

Rhinolithiasis is considered a rare condition with an incidence of 1 in 10,000 otorhinolaryngology patients (Sinha et al 1995). Unilateral mucopurulent foetid or nonfoetid discharge with nasal obstruction is the commonest presentation. Discharge may be purulent and blood tinged. Rare presentations like nasal septal perforation has been reported in the literature (Lumba et al 1973) but never before, to our knowledge, it has been reported to cause palatal perforation.

CASE REPORT

A 60 years male labourer working in a stone crushing unit attended otorhinolaryngology service at MGIMS Sevagram in June 2000 with complaints of obstruction and discharge from left nostril for 5 years. Earlier the discharge was whitish, sticky, non foul smelling and not blood tinged but since 3 weeks it became blood tinged and foul smelling. He also complained of regurgitation of fluid through left nostril while feeding since 1 week. There were no constitutional symptoms. There was no history of trauma, foreign body insertion or any systemic illness. Otorhinolaryngologic evaluation revealed a greyish irregular stony hard mass occupying the floor, inferior meatus and the space between the inferior turbinate and septum of the



Fig. 1 : Palatal perforation and oronasal fistula in a 60 years old masonary labourer with Rhinolithiasis.

left nostril along with a 2 x 1cm left paramedian palatal perforation (Fig.1) through which part of the nasal mass was protruding. There were a few granulations around the mass in the floor of left nostril. The mass was removed under topical anaesthesia with the help of Tilley's forceps (Fig.2) and granulation tissue sent for histological study. Haematological, biochemical, serological and radiological studies were unremarkable. Histological study of granulations revealed nonspecific chronic inflammation. Palatal perforation was repaired under local anaesthesia which healed by primary intention. The patient had no complaint in 6 months follow up.

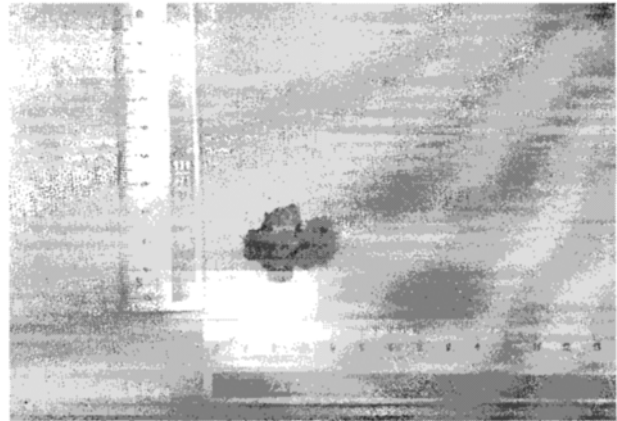


Fig.2 : Rhinolith removed from a 60 years old masonary labourer.

DISCUSSION

A foreign body, inspissated mucopus or even a blood clot acts as a nucleus for concretion and receives a coating of calcium, magnesium, phosphate, carbonate and becomes a rhinolith. Rhinolith may extend into the antrum requiring a Caldwell luc approach for removal or rarely it may become so large to require a lateral rhinotomy approach (Walby 1997). We believe our patient's masonary occupation predisposed to concretion of dust in the nasal cavity with subsequent deposition of insoluble mineral salts forming the rhinolith and the associated chronic inflammation and pressure necrosis led to perforation of hard palate producing

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an oronasal fistula. However we didn't encounter significant difficulty while removing the rhinolith and the palatal perforation healed well following primary repair of the mucoperiosteum.

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