Nasolabial cyst: a case report

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Abstract

Rhinoliths are uncommon clinical entities reported in clinical practice as unusual cause of unilateral nasal obstruction and foul-smelling nasal discharge. Rhinolith is a mineralized mass in the nasal cavity caused by the deposition of calcareous salts around an endogenous or exogenous nidus. A 30 years old male patient presented with 5-year history of right-sided nasal obstruction, foul-smelling nasal discharge and recurrent epistaxis. He received multiple courses of antibiotics and nasal steroids with no benefit. There is no history of trauma or insertion of a foreign body into the nose. Anterior rhinoscopy and nasal endoscopy revealed irregular shaped hard material with crustations and thick secretions around, stuck between nasal septum and inferior turbinate within right nasal cavity. Computed tomography scan of the paranasal sinuses showed large calcified mass extending along the floor of right nasal cavity. It was removed as two pieces by rigid endoscopy under local anesthesia and the nasal cavity irrigated. Surface cleaning of the mass revealed a metal-like stone. Anti-biotherapy was applied in postoperative period for one week. On follow-up at one week, the nasal cavity was in good condition and the symptoms were significantly reduced. The presence of a rhinolith, which is almost a forgotten entity, should be remembered in patients with unilateral nasal obstruction and foul-smelling nasal discharge, with or without sinusitis. Rigid nasal endoscopy is the method to be used in diagnosis and treatment. Treatment involves removal of rhinolith and use of appropriate antibiotic.

Introduction

Nasolabial cysts were identified first in 1882 by Zuckerkandl.1 Nasolabial cysts are more commonly in females. They are more frequent at the left side and they can be bilateral in 10%-ratio.2 Rao [3] recommended nasolabial cyst nomenclature and, it has been determined that it is developed from the soft tissues between the nasal vestibule and upper lip and, that it should be referred as nasoalveolar cyst provided that it leads to maxilla erosion. The patients refer mostly due to the swelling in the nasolabial sulcus and, cysts may be infected. Nasal obstruction and elevation signs of the upper lip can be seen.4 As the imaging method, a mass image can be seen in cystic structure localized in the soft tissue in the intensity of soft tissue in computerized tomography (CT). In the examination of Magnetic Resonance Imaging (MRI), hypertensive soft tissue intensity with regular boundary is observed in T1- and T2- sequences.5 In differential diagnosis, follicular, periodontal and residual cysts among the odontogenic cysts and neoplasms should be taken into account.2

Methods and Materials

Twenty-seven year-old woman was admitted to our clinic because of swelling that sprawl the upper lip from the bottom of leftside nose. The patient noticed swelling two years ago and no change in the size of the swelling for two years. Any surgical procedure is not applied to this area and there is no history of trauma. Patient was receiving medical treatment because of goiter. There is history of thirty pieces / day smoking. Physical examination showed round and well-circumscribed 2×2 cm mass that sitting on the left nasolabial groove. The moving mass was narrowing the nasal vestibul in front of the bottom of the inferior turbinate. We did not find signs of inflammation and infection (picture 1). Cyst is detected nonodontogenic at oral panoramic radiography. Cyst was seen as well-circumscribed mass near nasal vestibul that extended towards the bottom left side and made no destruction surrounding bone tissue at maxillofacial CT (picture 2). It was decided to surgical treatment. Sublabial excision surgery was performed. Left gingivalbucal incision made in surgery. Soft tissues were passed through blunt incision. Cyst was dissected from environmental soft tissues without denated. Gray-blue mass was removed. Any packing was not applied. The patient was discharged the same evening with analgesic pill. Pathological examination indicated benign cystic mass lined by respiratory epithelium. 1 week after surgery, the patient complained of bloody discharge from nose. No infection detected after surgery. Gradual deformity and blisters lost disharmony completely in the course of post-op. 1 month control examination (picture 3).

Discussion

Nasolabial cysts are seen in the second and fifth decades more commonly and, these cysts demonstrate preponderance in female gender and at the left side.4 Our case also shows all of these epidemiologic characteristics. Bull et al [6] reported that cystic mass, leading to swelling in the nasolabial region is a typical sign for nasolabial cyst. The complaint of referring of our case was facial deformity. El-Hamad [7] declared in their study that the patients reported that lesion develops within two to five years but since it grows slowly they do not request medical support.

The presence of swelling at the left side of the nasolabial region of our patient is consistent with literature. In the treatment of the disease, it is aimed to correct the deformity, to eliminate the nasal obstruction and to treat the infection if any. In our case, there was facial deformity and nasal deformity. The classical surgical treatment method for this lesion described in the literature is the removal of the cyst by means of sublabial approach.5 Lee et al [10] compared transnasal marsupialization and sublabial approach methods in their study conducted with twenty patients. They reported that transnasal marsupialization approach has shorter surgery time, lower complication ratio and complication time lasting shorter and that no recurrence has been observed in the one-year follow-up. In our patient, cyst was removed without blowing up the cyst in the plane of soft tissue by dissecting in the cyst excision procedure that we applied in our patient with sublabial approach. For the prevention of filling of the potential cavity formed in this procedure by hematoma or by seroma, necessary precautions should be taken. In our patient, the inability of applying dressing with compress in the first week following the surgery caused occur sometimes bloody discharge into the mouth.

Conclusions

In conclusion, nasolabial cyst is among those which can be confronted rarely by ear-nose-throat specialists. Although its diagnosis can be established clinically, additional imaging methods are required for the differential diagnosis. After the surgery that will be performed, the application of dressing with compression is effective in preventing the likely complications. We shared our knowledge about the diagnosis and the treatment of these cases by presenting a patient with nasolabial cyst diagnosis in the companion of the literature in this article.

References


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