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RHINOSPORIDIOSIS - A CASE REPORT

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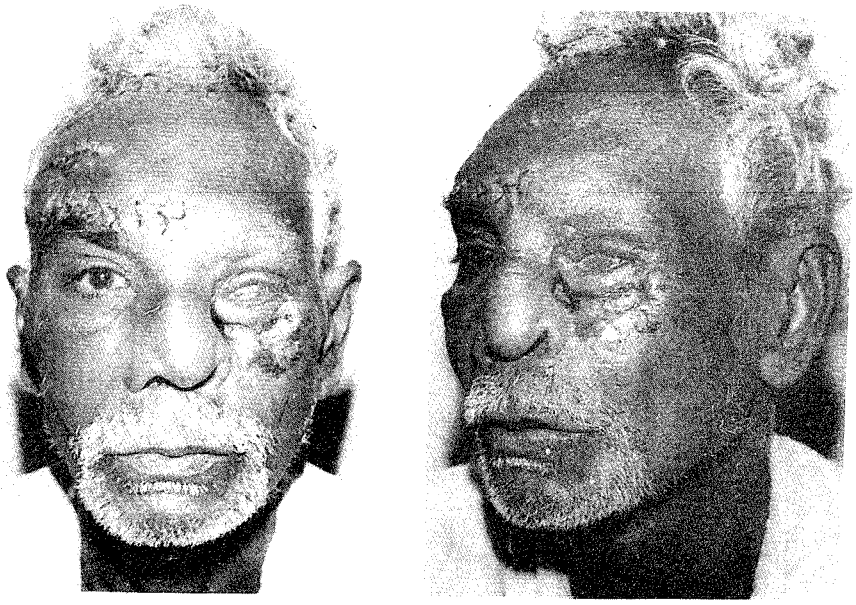
*SUMMARY. **A case of Rhinosporidiosis with an unusual feature of origin in the lower eyelid with spread to the naso-maxillary area and chronicity of 22 years is presented.***

CASE REPORT

A 57 year old male, originally a resident of Kerala was referred to Osmania General Hospital for the treatment of ulcer over the left cheek extending to the lateral wall of the nose and left orbit. The lesion started as a small nodule below the left lower eyelid in 1971 and gradually increased in size. The growth was excised and skin grafting was done at a local hospital. After an asymptomatic period of two years the lesion recurred thrice in three years. On each occasion local excision was done. Meanwhile a corneal ulcer developed in the left eye, which inspite of treatment, resulted in pthysical eye. In 1985 another excision of the recurrence was done and postoperative radiotherapy was instituted. In 1992 the patient developed dysphagia and was investigated in the ENT Department where a red polypoidal and pedunculated mass projecting from naso-pharynx to oral cavity was found. Excision biopsy revealed rhinosporidiosis. He came to our care for management of ulcer in the area (Fig 1 & 2).

On examination an ulcer over the left cheek of 1 cm x 3 cm in size was present with exposed bone in the floor. Edges were indurated and there was blackish discolouration all around. A fistula of 2 cm diameter was present in the left lateral wall of the nose. The lesion extended onto the left ala and the buccal sulcus. A skin nodule of 3 cm x 2 cm with a few satellite nodules were also seen in the forehead. There was no enlargment of regional lymph nodes. Excision biopsy of the skin nodules revealed rhinosporidiosis. X-ray showed erosion of bone in the infra orbital rim with haziness of left antrum.



(Fig - 1 & 2) Clinical picture of the patient with Rhinosporidiosis. The nodule in the forehead has been excised for biopsy

A wide excision of the lesion including resection of the left maxilla, enucleation of the left eye and excision of left half of nose was done. The resultant defect was closed with a folded total forehead flap. Deepithelialised portion at the site of folding was sutured to the cut edge of the nose. The cavity was filled with temporalis muscle flap.

Postoperatively there was gaping of the inset in the superior margin of the defect exposing the frontal bone. This was excised and flap adjustment done. Subsequently the wound healed well.

DISCUSSION

Rhinosporidiosis is a fungal infection affecting the nose, eyes, ears, larynx and occasionally the penis, vagina and rectum. Rhinosporidiosis seeberi, the causative agent, though assumed to be a fungus, has never been cultured. It is common in Sri Lanka and India. It is not known as to how the infection occurs but immersion in dirty and stagnant water has been attributed.

The lesion usually takes the form of polyps which are soft, pink and nodular. Greyish white areas occur over the pink surface and these consist of large fungal cells (sporangia) containing numerous spores. The surrounding areas consist of edematous mycematous stroma infiltrated with chronic inflammatory cells. Sporangia are thick walled. Presenting features are localised pruritus with mucoid discharge. After months or years, soft and vascular polyps develop which become pedunculated. As they enlarge they become obvious, for example at the anterior nostril or at the pharynx. This may give rise to nasal obstruction, dyspnoea and dysphagia. Contiguous lesions sometimes spread on to the face and probably our patient belonged to this group. The lesions may also resemble venereal warts. Vaginal granulamata may simulate condylomata and rectal involvement may be confused with rectal polyps.

Diagnosis is by demonstrating a large number of typical sporangia. Management is by surgical excision of the early lesions.

The case is reported for its rarity and uncommon presentation of dysphagia. This was probably because of the growth projecting into the oral cavity. The treatment is surgical excision of lesions with wide margins. Repeated recurrences in this case probably indicate inadequate excision at the earlier stages. When a wide area is excised a plastic surgical reconstruction may become necessary.

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