

Case Report

Isolated epiglottic rhinosporidiosis: a rare case report

Aurobinnda Das, Rajat Kumar Dash*, Kamalini Bepari

Department of ENT, VIMSAR, Burla, Sambalpur, Odisha, India

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*Correspondence:

Dr. Rajat Kumar Dash,

E-mail: rajatdash84@gmail.com

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ABSTRACT

Rhinosporidiosis is a chronic granulomatous disease, caused by *Rhinosporidium seeberi*. More than 70% of cases are nasal. Usually extranasal rhinosporidiosis is associated with nasal rhinosporidiosis. Isolated extra nasal variety of laryngeal and tracheal rhinosporidiosis are very rare, 7 cases has detected till date. A 45 years male of LSES with habit of pond bath presented to ENT OPD, VIMSAR, Burla, with chief complain of intermittent blood vomiting for last 30 days, associated with foreign body sensation in throat without any dysphagia or dyspnea. On ILE, there is polypoidal pinkish mass studded with white spots found at lingual surface of epiglottis. Ant and post rhinoscopic examination found to be normal. UGIE guided biopsy shows rhinosporidiosis mass. Under GA, DL had done mass was excised and base cauterised with bipolar cautery and send for HPE. HPE confirmed the diagnosis. Post operative follow up upto 10 months showed no recurrence. Epiglottic rhinosporidiosis may be one of the differential diagnosis of epiglottic growths especially in endemic zone. Laryngeal involvement of rhinosporidiosis has diagnostic and therapeutic challenges, due to the potential risk of bleeding, aspiration and recurrence.

Keywords: Rhinosporidiosis, Epiglottis, Isolated, Extranasal

INTRODUCTION

Rhinosporidiosis is a chronic granulomatous disease, caused by *Rhinosporidium seeberi*.¹ It belongs to the class protostistan mesomycetozoa.² Most common in Southern India and Srilanka.³ Contaminated stagnant fresh water is an important source of infection.^{4,5} It mostly affects nasal mucosa, ocular conjunctiva and nasopharynx.^{1,6-9} More than 70% of cases are nasal.¹ Usually extra nasal rhinosporidiosis is associated with nasal rhinosporidiosis. Extra nasal variety of laryngeal and tracheal rhinosporidiosis are very rare.^{8,10,11} Six cases has been detected involving larynx till date.^{7,10-13} Our case is the seventh reported case involving larynx. More prevalence in male of the age group of 15 to 50 years with low SES. Male to female ratio of 4:1.¹⁴ Most of these patients have history of pond bath. Mostly present as polypoidal pinkish nasal mass studded with white spots with intermittent blood tinged nasal discharge.⁵

Medical treatment is ineffective. Surgical excision is mode of treatment, however recurrence is common. HPE confirm the clinical diagnosis.

CASE REPORT

Forty five years married Hindu male, farmer by occupation from Jharsuguda district, presented to ENT OPD, VIMSAR, Burla, with chief complain of intermittent blood vomiting for last 30 days, associated with foreign body sensation in his throat. He had no complained of difficulty in swallowing or breathing. There was no history of previous rhinosporidiosis. He had no history of bleeding disorder or chronic disease like TB. He belongs to LSES (low socio economic status) and has habit of pond bath. On examination higher function and vitals of the patient found to be normal. He had mild pallor and thin body built. Face and dorsum of nose found to be normal (Figure 1). Oral cavity, posterior

pharyngeal wall examination found to be normal. On ILE (indirect laryngeal examination), there is polypoidal pinkish mass studded with white spots found at lingual surface of epiglottis. Ant and post rhinoscopic examination found to be normal. UGIE (upper gastrointestinal endoscopy) guided biopsy shows rhinosporidic mass (Figure 2). Then patient was planned for surgical excision. Under GA (general anaesthesia), DL (direct laryngoscopy) was done. Attachment of mass to the lingual surface of epiglottis identified (Figure 3). The mass was excised and base cauterised with bipolar. The excised mass was send for HPE (Figure 4). Histopathological examination confirmed the diagnosis (Figure 5). Patient was kept nil per oral with Ryles tube feeding and prophylactic antibiotic for 3 days. HPE confirm the clinical diagnosis. Post opwrative follow-up upto 12 month showed no recurrence (Figure 6).



Figure 1: Patient showing no facial deformity.



Figure 2: Upper gastrointestinal endoscopy finding.



Figure 3: Excised mass.



Figure 4: Intra OP picture showing site of attachment.

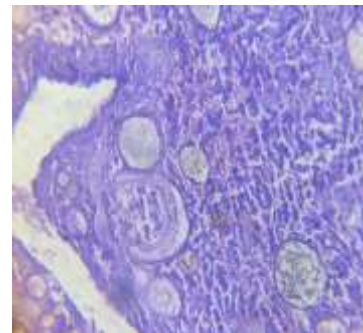


Figure 5: Histopathological examination finding.



Figure 6: Follow up laryngeal endoscopic photo showing no recurrence after 12 month.

DISCUSSION

Rhinosporidiosis mostly affects nose and nasopharynx, other sites such as conjunctiva, palate, lip, epiglottis, larynx, trachea, skin, vulva and bone may also be affected.⁶ More than 70% of cases are nasal.¹ Extra nasal rhinosporidiosis is usually associated with nasal rhinosporidiosis. Extra nasal variety of laryngeal & tracheal rhinosporidiosis are very rare, 7 cases has been detected till date including our case. However isolated epiglottic rhinosporidiosis is very rare. Patient seeks medical attention late as compared to nasal variety. Pond bathing with injury at extra nasal mucosa, may predispose to extra nasal variety. Proper history & oropharyngeal, laryngeal examination may help to reach the diagnosis. Histopathology study confirms the diagnosis. Excision with wide base cauterisation is the

treatment of choice Intermittent follow up with post operative dapsone may be given to reduce recurrence. Differential diagnosis is carcinoma, squamous papilloma, ductal epiglottic cyst, fibroepithelial polyps, tubercular mass.¹⁵

CONCLUSION

As a rare case and asymptomatic for long time, the case may be missed by physician in first instant, hence all suspected case should be examined and investigated in the line of rhinosporidiosis, especially in endemic zone. Epiglottic rhinosporidiosis may be one of the important differential diagnosis of epiglottis growths. Laryngeal involvement of rhinosporidiosis may possess diagnostic and therapeutic challenges, due to the potential risk of bleeding, aspiration and recurrence.

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